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Having a known, trusted support person during labour and birth: Perceptions of Indonesian (Javanese) women, their support persons and midwives

Natalia
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**Having a Known, Trusted Support Person during Labour and Birth:
Perceptions of Indonesian (Javanese) Women, Their Support Persons and Midwives**

This thesis is presented for the degree of

Doctor of Philosophy

Natalia

Edith Cowan University

School of Arts and Humanities

2019

ABSTRACT

Childbirth is a life changing experience for women, yet most women feel anxious with regard to this event. Research has shown that support from family or friends can help to reduce women's anxiety intrapartum, however, the standard procedure at most maternity centres in Indonesia is to not allow any person in the birthing room except midwives.

This study investigated the impact of the presence of a support person on the anxiety of women giving birth in Surabaya, Indonesia. The originality of this study is in trying to understand the 'whole picture' about support during labour and childbirth by listening to women, their support persons, and midwives who care for them during this episode. Most studies have looked at this experience from women's or support persons' perceptions only, however, it is important to hear from caregivers as well in order to understand the phenomenon fully. The findings provide the basis of recommendations about for Indonesian maternity care, particularly those within the Javanese culture.

A qualitative approach, specifically narrative inquiry, was used to answer the following research questions: How do childbearing women birthing in an Indonesian (Surabaya) maternity centre interpret the presence of a known, trusted support person and experience their impact on their birth-related anxiety? How do support persons experience their role during labour and childbirth? How do midwives experience the support during labour and childbirth? Twenty-one women, their support persons, and midwives who provide intrapartum care participated in this study. Data were collected from March to December 2016.

The major finding of this study was that the key factor in whether women felt supported or not during labour and childbirth depended on how well prepared, emotionally available and ‘on their side’ their support persons was. Well prepared, emotionally available and ‘on side’ support persons were perceived as trustworthy by the women. When supported by this type of support person, the participant women had positive experiences of labour and childbirth. In contrast, unengaged support persons who were not ‘on side’ were perceived as not trustworthy by the women. As a consequence of having this type of support person with them intrapartum, the women had a negative experience of labour and childbirth. Therefore, this study recommends preparation classes for potential support persons so they can provide effective support for women during labour and childbirth. This study has the potential to contribute to improvements in maternity care services for childbearing women, support persons, and midwives in Indonesia, particularly those within the Javanese culture, and other countries with a similar birthing culture.

Keywords: anxiety, childbirth, support person, Indonesia.

I certify that this thesis does not, to the best of my knowledge and belief:

- i. incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education;
- ii. contain any material previously published or written by another person except where due reference is made in the text of this thesis; or
- iii. contain any defamatory material.

March 2019

Natalia

*"Here I am, the servant of the Lord;
let it be with me according to your word."
(Luke 1: 38)*

Thanks be to God and Holy Mary for the blessing and mercy
through the Hail Mary Novena and Rosary Prayer

*Kupersembahkan karya sederhana ini untuk keluargaku tercinta, teristimewa untuk adikku tercinta, **Cyrilla Johanna Siswajanti**, satu-satunya orang yang menjadi Ibu dari anak-anak orang tua kami, dan keponakanku tercinta, **Cyrilla Callysta Michelle Oetomo**, satu-satunya generasi penerus keluarga kami.*

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The loveliest masterpiece of the heart of God is the heart of a mother (Unknown).

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LIST OF TERMS

This listing includes Indonesian, Javanese and other terms.

| | |
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| <i>Adrenocorticotrophic hormone (ACTH)</i> | Hormone produced by the anterior pituitary. |
| <i>Alhamdulillah</i> | Islamic term to express praise be to God. |
| <i>Ana sethithik dipangan sethithik</i> | There is a little, a little should be eaten. |
| <i>Angkot</i> | Indonesian term for public transport, short for <i>angkutan kota</i> . |
| <i>Apgar Score</i> | Score of 0 – 2 given to each newborn's A ppearance (skin colour), P ulse (heart rate), G rimace response (reflex), A ctivity (muscle tone), and R espiration (breathing rate) at 1 |

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| | and 5 minutes after birth. |
| <i>Ari-ari</i> | Placenta. |
| <i>Arma</i> | The middle level of Javanese language structure. |
| <i>Arma inggil</i> | The highest level of Javanese language structure. |
| <i>Aruman</i> | Placenta. |
| <i>Asphyxia neonatorum</i> | A newborn's condition when s/he does not breath spontaneously and regularly after birth. |
| <i>Bakti</i> | Being filial to their husband or parent. |
| <i>Bebet</i> | A Javanese philosophy when choosing a child-in-law that considers as significant the financial status of the individual. |
| <i>Bibit</i> | A Javanese philosophy when choosing a child-in-law that considers “seeds”, that is, the background of the family as |

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| | significant: the profession and the status of the parent of potential child-in law in the community. |
| <i>Bobot</i> | A Javanese philosophy when choosing a child-in-law that considers as significant the quality of the physical and psychological condition of the individual (i.e., the physical appearance, their faith, kindness & manners). |
| <i>BPS</i> | Short for B adan P usat S tatistik or Statistics Indonesia. |
| <i>Brojolan</i> | One part of <i>Tingkeban</i> ceremony. |
| <i>Caesarean childbirth</i> | Unplanned caesarean childbirth |
| <i>Catecholamines</i> | Hormones produced by adrenal glands. |
| <i>CIA</i> | Central Intelligence Agency. |
| <i>Dinas Kesehatan Kota Surabaya</i> | Department of Health of city of Surabaya. |

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| <i>Dukun bayi</i> | Traditional healer/midwife in Indonesia. |
| <i>Empon-empon</i> | Spices. |
| <i>Gading coconut</i> | An Indonesian specific type of coconut. |
| <i>Garwa</i> | Short for <i>sigaraning nyawa</i> , meaning a spouse. |
| <i>God Kamajaya</i> | A handsome god according to Javanese belief. |
| <i>Goddess Kamaratih</i> | A beautiful goddess according to Javanese belief. |
| <i>Ikatan Bidan Indonesia (IBI)</i> | Indonesian Midwives Association. |
| <i>Insyallah</i> | Islamic term to express if God permits. |
| <i>Jampersal</i> | Short for Jaminan Persalinan (childbirth insurance/guarantee paid by the Indonesian government). |
| <i>Kain</i> | Cloth. |
| <i>Kakang kawah adi ari-ari</i> | Javanese's belief that amniotic fluid is a spiritual older brother |

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| | of the baby; placenta is a spiritual younger brother of the baby. |
| <i>Kampung</i> | Indonesian/Javanese term indicating a high density area that comprises of small houses in small lanes. |
| <i>Kawah</i> | Amniotic fluid. |
| <i>Keadaan slamet (ora ana apa-apa)</i> | Being in a state of safety, without disturbance. |
| <i>Kembang setaman</i> | Flowers used for traditional ceremonies that consists of rose, yasmin, magnolia, and cananga. |
| <i>Kementerian Sekretariat Negara Republik Indonesia</i> | Ministry of State Secretariat of the Republic of Indonesia. |
| <i>Kementrian Kesehatan Republik Indonesia</i> | Ministry of Health of the Republic of Indonesia. |
| <i>Kendhil</i> | Clay bowl. |
| <i>Kodrat</i> | Intrinsic nature. |
| <i>Lebaran</i> | <i>Eid Al-Fitr</i> , a religious celebration for Muslim. |
| <i>Mangan ora mangan asal kumpul</i> | Javanese popular proverb that |

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| | means eating or not eating, the most important is being together. |
| <i>MDG</i> | M illennium D evelopment G oals. |
| <i>Mendhem Ari-ari</i> | Javanese traditional ceremony to bury the placenta with respect. |
| <i>Mitoni</i> (or <i>Tingkeban</i>) | An important Javanese traditional ceremony in the seventh month of pregnancy. |
| <i>Mori clothes</i> | Calico. |
| <i>Mudik nasional</i> | National returned to home village during <i>Lebaran</i> . |
| <i>Ngidam</i> | Indonesian term for a ‘pregnancy craving’ |
| <i>Ngoko</i> | The lowest level of Javanese language structure. |
| <i>Ngupati</i> | Javanese traditional ceremony in the fourth month of pregnancy. |
| <i>Normal childbirth</i> | Vaginal childbirth |

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| <i>Nrimo</i> | Accepting of everything that happens in their life. |
| <i>Nurut</i> | Being obedient. |
| <i>Nusantara (Kepulauan Antara)</i> | An In Between Archipelago. |
| <i>Pancasila</i> | <p>The philosophical basis of Indonesia which consists of five principles:</p> <ol style="list-style-type: none"> 1. Belief in One Supreme God. 2. Just and civilized humanity. 3. Unity of Indonesia. 4. Community led by wisdom in consultation/representation. 5. Social justice for all the people of Indonesia. |
| <i>Pasrah</i> | Submit everything to God's will or fully succumbing to destiny, submitting/surrendering everything totally to others such |

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| | as God, husband, parent, or midwives. |
| <i>Pemerintah Kota Surabaya</i> | Government of city of Surabaya. |
| <i>Pepadhang</i> | A light in the dark. |
| <i>Pertemuan Ilmiah Tahunan Bidan I</i> | The First Indonesian Midwives Association Annual Scientific Meeting. |
| <i>Polindes</i> | Short for <i>pondok bersalin desa</i> or village childbirth cottage. |
| <i>Poskesdes</i> | Short for <i>pos kesehatan desa</i> or village health station. |
| <i>Preeclampsia</i> | A disorder during pregnancy and after giving birth characterized by high blood pressure. |
| <i>Puskesmas</i> | Short for <i>pusat kesehatan masyarakat</i> or public health centres. |
| <i>Puskesmas mampu PONED</i> | Short for <i>Pelayanan Obstetrik Neonatal Emergensi Dasar</i> or public health centres providing |

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| | basic emergency neonatal obstetric service. |
| <i>Rukun</i> | A condition that all parties are in a peaceful condition, love to cooperate, accept each other in a calm and agreed situation. |
| <i>Sabar</i> | Being patient. |
| <i>Selapan</i> | Javanese traditional ceremony to celebrate of 35 days old of the baby born. |
| <i>Senthe leave</i> | A type of plant/leave named <i>Alocasia Macrorrhizos</i> in Latin. |
| <i>Sethithik</i> | A very small number. |
| <i>Setia</i> | Being loyal. |
| <i>Sholawat</i> | A type of Islamic prayer. |
| <i>Sji pati, loro jodho, telu tibaning wahyu</i> | First rice, second soul mate, third wealth. This means that God has administered food, a soul mate, and wealth to people. |
| <i>Sujud syukur</i> | Indonesian term expressing prostration of gratitude to God |
| <i>Sunnah</i> | Islamic term means |

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| | obligatoriness. |
| <i>Tidak tega</i> | It includes both the speaker's <i>compassionate</i> and <i>fortitudinous</i> (translated as 'fortitudinous' in the direct quotations presented in this thesis. ' <i>tidak tega</i> ' can be translated as ' <i>not fortitudinous</i> '. |
| <i>Tingkeban</i> (or <i>Mitoni</i>) | An important Javanese traditional ceremony in the seventh month of pregnancy. |
| <i>Tiyang alit</i> | Unworthy people. |

CHAPTER 1: INTRODUCTION

1.1 Background

Based on 26 trials exploring the benefits of providing continuous support to women during labour and childbirth in 17 high income and middle income countries, the World Health Organisation (WHO) (WHO, 2017) has recommended that women be accompanied by a trusted support person during labour and childbirth. This WHO recommendation, however, is not yet applied consistently in Indonesia despite a 2013 recommendation by Indonesia's Ministry of Health in cooperation with the WHO, Indonesian Obstetrics and Gynaecology Association, and Indonesian Midwives Association that a support person (family member) accompany women during labour and childbirth (Kementrian Kesehatan Republik Indonesia, 2013). It is still uncommon in Indonesia to have a support person (family member) accompany women during labour and childbirth (Defiany, Sumarni, Febriarni, Fatonah, & Erlyta, 2013; Johariyah, Sohimah, & Lestari, 2014; Magfuroh, 2012; Sektiawan, 2010; Stiarti, 2011) as anecdotally, Indonesian midwives oppose having anyone other than health care professionals enter childbirth rooms.

The World Health Organization (WHO, 2017) has also recommended that further research about support during labour and childbirth be conducted in low-income countries. Any such study in Indonesia, which is categorized as a lower middle-income country, contributes to addressing this WHO recommendation.

The benefits of having the support of a known trusted (lay) support person intrapartum for women regardless of where they reside are well known include (Astutik & Sutriyani, 2017; Baker, 2010; Defiany et al., 2013; Diponegoro & Hastuti, 2009; Dlugosz, 2013; Field, 2010; Johariyah et al., 2014; Kartini, 2011; Klaus, Kennell, Robertson, & Sosa, 1986; Lailia & Nisa, 2015; Langer, Campero, Garcia, & Reynoso, 1998; Primasnia, Wagiyo, & Elisa, 2013; Reynolds, 1988; Torres, 2015). Some studies about support during childbirth have been conducted in Indonesia (Astutik & Sutriyani, 2017; Defiany et al., 2013; Diponegoro & Hastuti, 2009; Johariyah et al., 2014; Kartini, 2011; Lailia & Nisa, 2015; Primasnia et al., 2013; Sektiawan, 2010). Those studies are, however, inconsistent, unclear and do not adequately discuss many important issues. Both those studies and most other previous studies of support during labour and childbirth have only investigated the women's or the support persons' perspectives and have failed to investigate the midwives' perspectives. Given the disparity between the Indonesian Midwives Association support for the presence of support persons in birthing rooms (Kementrian Kesehatan Republik Indonesia, 2013) and midwives' apparent practice of excluding such persons (Defiany et al., 2013; Johariyah et al., 2014; Magfuroh, 2012; Sektiawan, 2010; Stiarti, 2011), there is a need for further Indonesian studies that explore the issue in depth and include midwives' perspectives.

Investigating women's, support persons' and midwives' differing experiences of and perspectives on support during labour and childbirth would provide a more comprehensive understanding of support during labour and childbirth. Understanding the 'whole picture' would in turn help ensure policy development and implementation in relation to lay support in labour took account of all the barriers and drivers.

Any such Indonesian study needs to take account of national and local factors and relevant cultural considerations. The next section, therefore, provides more background on the Indonesian context.

1.2 Indonesia - Overview

As Figure 1 shows, the Republic of Indonesia is located in South East Asia. The name Indonesia is derived from two Greek words, “Indos” meaning “Hindia”, and “Nesos” meaning “Archipelago” (Cholil, Iskandar, & Sciortino, 1999). As Indonesia is located between two continents (Asia and Australia) and two oceans (the Pacific Ocean and the Indian Ocean) it is also known as *Nusantara (Kepulauan Antara)*, an In-Between Archipelago (Kementerian Sekretariat Negara Republik Indonesia, 2018). It consists of 17,508 islands and is the world’s largest archipelago country (Cholil et al., 1999; Kementerian Sekretariat Negara Republik Indonesia, 2018). Its 6,000 inhabited islands include the five main islands of Irian Jaya, Java, Kalimantan, Sulawesi, and Sumatra (Cholil et al., 1999; CIA, 2018). According to the United States Census Bureau (2018), Indonesia's population of 262,787,403 was the fourth largest in the world in 2018 and the Indonesian annual population growth rate in 2014 – 2015 was 0.94 % (United States Census Bureau, 2018).



Figure 1. Map of Indonesia. Adapted from “The World Fact Book 2018”, by CIA, 2018.

Copyright 2018 by Central Intelligence Agency.

Indonesia's official national motto is *Bhinneka Tunggal Ika* meaning unity in diversity. While the nation's official language is Bahasa Indonesia, more than 700 languages are used in Indonesia and many people use their local traditional language (CIA, 2018). In 2010, the many ethnicities include Javanese (40.1%), Sundanese (15.5%), Malay (3.7%), Batak (3.6%), Madurese (3%), Betawi (2.9%), Minangkabau (2.7%), Buginese (2.7%), Bantenese (2%), Banjarese (1.7%), Balinese (1.7%), Acehnese (1.4%), Dayak (1.4%), Sasak (1.3%), Chinese (1.2%), and other (15%) (CIA, 2018).

The country of Indonesia based on a philosophical basis which consists of five principles named *Pancasila* (Frederick & Worden, 1993). Regarding to its first principle that is belief in One Supreme God (Frederick & Worden, 1993), Indonesia's large population has a wide variety of religious beliefs and cultural traditions and the Indonesian government requires Indonesian people to state their religion on their identity

card. According to CIA World Factbook (2018), the religions in Indonesia include Islam (87.2%), Protestant Christianity (7%), Roman Catholicism (2.9%), Hinduism (1.7%) and others including Buddhism and Confucianism. Even though it is not a Muslim country, but based on *Pancasila* as a philosophical basis (Frederick & Worden, 1993), Indonesia has the largest Muslim population in the world (Kementerian Sekretariat Negara Republik Indonesia, 2018). The importance of religion is very evident throughout Indonesia. Many places in Indonesia reverberate five times a day to Islamic calls to prayer and television and radio broadcasts also remind people of the Islamic prayer times.

Dickson (2018) cites *Badan Pusat Statistik* (BPS) Indonesia (Statistics Indonesia) as indicating that the Indonesian population is spread across 34 provinces, with the most populous provinces being West Java (47,379,400 people or 18.3% of the population), East Java (39,075,300 people or 15.1% of the population), and Central Java (34,019,100 people or 13.1% of the population).

Java is not only Indonesia's most populated island, but also one of the world's most densely populated areas (CIA, 2018). It contains both of Indonesia's major cities, the national capital Jakarta and the second largest city, Surabaya. According to BPS as cited in Databoks (2018), the population of Indonesia's capital city Jakarta increased from 10.18 million in 2015 to 10.28 million in 2016 and 10.37 million in 2017. By contrast, Surabaya has only 2.903 million people (CIA, 2018).

1.3 Indonesia – Social Hierarchies

A person's age, status, and power determine their place in Indonesian social hierarchies (Business View, 2015). Children defer to parents or elder people or elder

brothers or sisters, students to teachers, patients to doctors, pregnant women to midwives, staff to supervisors, managers or directors.

Most Indonesians from a middle to lower socio-economic level background tend to see themselves as “*tiyang alif*” or unworthy people (Satoto, 2004; Suryadi, Subroto, & Marmanto, 2014). As “*tiyang alif*”, they see those people of a higher socio-economic level as more educated and expert and feel obliged to respect and obey or at least follow the advice of those people because they must know much better than the “*tiyang alif*”, (Satoto, 2004; Suryadi et al., 2014).

In the health area, the hierarchy extends down from specialist doctors, chief doctors, specialist doctor students, junior doctors, to midwives, nurses, and patients. Patients deem the health care staff to be the experts, trust them and feel they should obey the health care staff's directions.

Most Indonesian women, because of the health care hierarchy, had no freedom to exercise choice during their childbearing experience. Conversations with the doctors and midwives at the maternity centre at which this study was situated confirmed this to be the case. The cultural norm is that doctors or midwives decide what happens to women, and women accept this state of affairs on the basis that the ‘doctor (or the midwife) knows best’.

Regarding experiences of support during labour and childbirth, Javanese values might influence the women of this study, and their support persons. The relevant Javanese values are described below to further explain the context of this study.

The concept of *pasrah* is important to consider. Endraswara (2016) argued that *pasrah* assumes that Javanese people can put effort into something but are not authorized to determine an outcome, as only God can decide their destiny.

The phrase *ana sethithik dipangan sethithik*, which means if there is a little, a little should be eaten (Endraswara, 2016), is also relevant to this study and participants' inability to articulate expectations. Endraswara (2016) said that this philosophy teaches Javanese people that one should not be too ambitious in life, not force themselves too hard, and accept things just the way they are. He argued that the concept of *sethithik* means that Javanese people will accept anything in life that is given by God. He continued that this philosophy is applied to their entire life. It means Javanese people consider that expecting or planning something in too much detail is too ambitious. Furthermore, Endraswara (2016) argued that Javanese people believe that there is a god who administers *siji pati*, *loro jodho*, and *telu tibaning wahyu*, which means that there is a god who administers food, a soul mate, and wealth. *Wahyu* means a grace from God to people.

Satoto (2004) said that in Rachmawati's study of pregnancy and childbirth all the women hesitated to complain because they felt they were "*tiyang alit*" (unworthy people) and, therefore, they must completely trust the health service as stated by one of the participants in her study (Rachmawati, 2004):

Nggih mboten pingin ngadu lah, nggih pripon sih mboten napa-napa wong rumah sakit kan carane lebih pinter daripada tiyang dusun, nggih mendel mawon lah mboten pingin protes. Wong kula niki tiyang alit, griya sakit niku tiyang pinter-pinter. Mangke nek kula protes mboten saget nangani pripon [Tidak ingin

mengadu, ya tidak apa-apa soalnya rumah sakit orangnya lebih pandai dari orang desa, ya diam saja tidak ingin protes. Soalnya saya ini orang kecil, rumah sakit itu orang pandai-pandai. Nanti kalau saya protes tidak bisa menangani bagaimana] (104, 32 tahun, Kalimalang) (p. 150)

[Do not want to complain, never mind because hospital staff are smarter than people from village, just keep silent do not want to complain. Because I'm only unworthy people, hospital staff are smart people. If I complain then how if they do not want to serve anymore. (104, 32 years old, Kalimalang)] (p. 150)

The differences in socio-economic status of the Javanese people is also reflected in traditional Javanese language. Suryadi et al. (2014) argued that there are some levels in Javanese that are used in different contexts: *ngoko*, *arma*, until *arma inggil*. They pointed out that the use of language is important in Javanese culture because it identifies the strata of the group. Purwoko (2008 as cited in Suryadi et al., 2014) stated that *ngoko* is used by *tiyang alit* or the lower level of the Javanese community. Suryadi et al. (2014) explained that to show respect to the higher level of the Javanese community, people should use *arma* or even *arma inggil*. Clearly, this characteristic of the Javanese language cannot be separated from the cultural, social, and psychological aspects of Javanese people. As well as midwives to women, other examples of respecting and obeying those who are 'higher' than Javanese lower level groups are parents to children, and teachers to students (Suryadi et al., 2014; Suseno, 1996).

There is also a Javanese principle – *rukun* – that is relevant to this study. Suseno (1996) stated that *rukun* is defined as a condition where all parties are in a peaceful condition, love to cooperate, and accept each other in a calm and agreed manner. He said

that *rukun* is an ideal condition in all types of relationship. People should be able to control their emotions to avoid conflict (Suseno, 1996).

According to Endraswara (2016) there is also a Javanese philosophy that a peaceful world is the ideal goal of Javanese people. He said that it is reflected in the concept “*keadaan slamet (ora ana apa-apa)*”. This means to be in a state of safety, without disturbance (Endraswara, 2016).

Finally, Negoro (2000) stated that the Javanese culture requires women to fully obey their husband. He said that this is symbolized in the Javanese traditional wedding ceremony, which includes the ritual of *Wiji Dadi* (see Figure 2). He explained that in this ritual the bridegroom crushes a chicken egg with his right foot, which is then washed by the bride using water mixed with several kinds of flowers. It depicts that the bridegroom is ready to become a responsible father and the bride should faithfully serve her husband (Negoro, 2000).

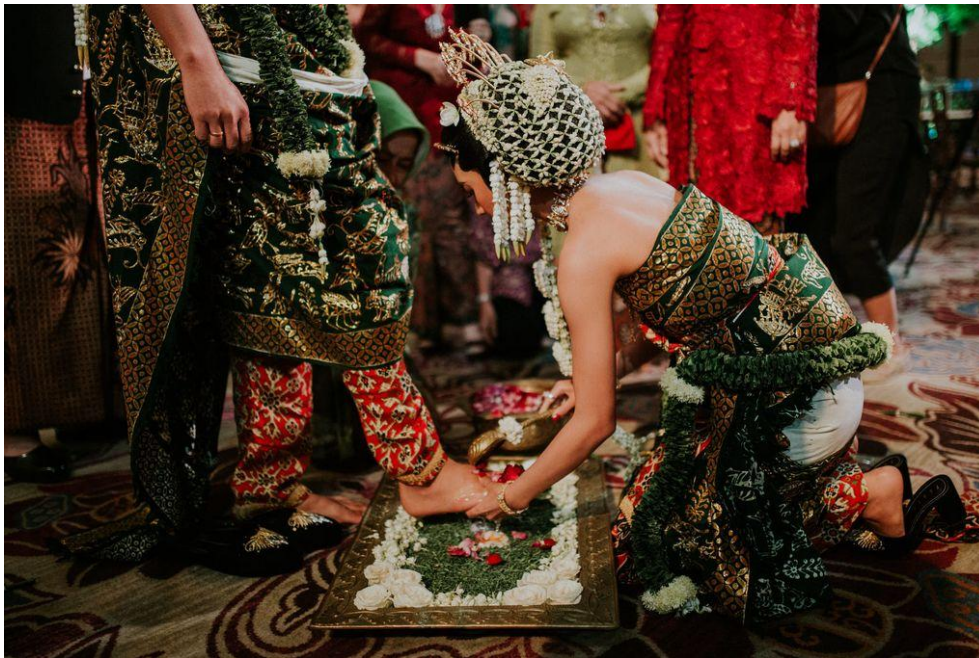


Figure 2. The ritual of *Wiji Dadi*

The ritual of *Wiji Dadi* positions Javanese women as submissive, and dictates that they must fully obey those who are more superior (Negoro, 2000). In Indonesian society, where women are subordinate, this expectation on both sides of women's obedience and deference extends to the relationship between birthing mothers and midwives, doctors, and other healthcare professionals, who are considered superior to women.

1.4 Indonesia – Gender and Family Considerations

Indonesian women's childbirth experiences need to be understood in the context of women's roles and status within Indonesian society and culture. As Tiwon (1996, cited in Wieringa (1996) stated, Indonesian women are expected to be always in relationships with their husband and children. The Indonesian term *ibu* means both wife and mother and women are expected not to stray from *kodrat* (an Indonesian term meaning intrinsic nature) of giving birth and nurturing their babies (Curnow, 2007; Endraswara, 2018; Maharani & Andayani, 2003; Wieringa, 1996). According to Wieringa (1996), 'the *kodrat* of Indonesian women prescribes that they should be meek, passive, obedient to the male members of the family, sexually shy and modest, self-sacrificing and nurturing, and that they find their main vocation in wifedom and motherhood'. There is a widely shared view that Indonesian society prefers women to be passive and shy (Curnow, 2007; Endraswara, 2018; Maharani & Andayani, 2003; Sadli, 1984; Wieringa, 1996).

There is a clear division of the roles between the husband and wife (Maharani & Andayani, 2003). A husband's primary role is to provide financial support for his family, while a wife's role is to stay home to clean the house, wash the family's clothes, and prepare food for the family (Maharani & Andayani, 2003). Indonesian married women

are expected to focus on housework and serving their husband (Curnow, 2007; Sadli, 1984; Wieringa, 1996) as their primary duty and to always respect and obey their husbands (Curnow, 2007; Sadli, 1984; Wieringa, 1996).

Some stills from a film about the life of Kartini, Indonesian's national female heroine who lived in the early 1900s, show how strongly gender considerations once influenced Javanese women's everyday lives. As the way she sat and moved had to ensure that her head remained lower than that of a man, Kartini and other Javanese women would sit on the floor while a man occupied a chair (Figure 3) and would adopt a squatting position when walking (Figure 4).



Figure 3. Javanese women sitting on the floor as shown in the movie 'Kartini'. Reprinted from "Menyimak Peran Dian Sastro di Film Kartini" by P. Elmira, 2017. Retrieved from <https://www.bintang.com/celeb/read/2694442/menyimak-peran-dian-sastro-di-film-kartini#> Copyright by bintang.com KLY KapanLagi Youniverse



Figure 4. Javanese women walking by squatting as shown in the movie ‘Kartini’.

Reprinted from 5 Curhatan mencengangkan Dian Sastro soal film Kartini by Tanjung (2016). Retrieved from <https://www.brilio.net/selebritis/5-curhatan-mencengangkan-dian-sastro-soal-film-kartini-1607176.html>

While many of those practices have disappeared, Sadli (1984) holds that Javanese women are still more valued in their community if they live in accordance with key Javanese concepts relating to:

- *nrimo* (accepting of everything that happens in their life),
- *pasrah* (submitting/surrendering everything totally to others such as God, husband or parents),
- *nurut* (being obedient),
- *sabar* (being patient),
- *setia* (being loyal), and
- *bakti* (being dedicated to their husband and parents).

The most demanding idealised traits for Javanese women is that they should be *nrimo* and *pasrah* (Endraswara, 2018; Sadli, 1984). The disadvantaged financial state of

the majority of Javanese women, particularly in villages, leaves them with little alternatives to developing these stereotypical traits (Sadli, 1984).

Marriage profoundly changes a woman's status and relationship and sources of family support. A well-known idiom in Indonesia states that a marriage in Indonesia is not just a marriage between two individuals, but between two extended families. Javanese families in particular place great weight on *bibit*, *bebet*, *bobot*. *Bibit* relates to the background of the family, such as a parent's profession and the status in the community (Saka, 2015). *Bebet* refers to the financial status of the individual as this is important for the family life (Saka, 2015). *Bobot* refers to an individual's physical and psychological condition and covers aspects such as physical appearance, faith, kindness and manners (Saka, 2015).

When choosing a spouse, individuals usually request permission from their family, and even their extended family. A marriage may, for instance, be cancelled if an uncle of the intended spouse is not in favour of the marriage. This is understandable in the context of the support routinely provided to family members. When individuals have a problem, they routinely seek and receive support from their family. It is, for instance, very common for children to be raised by their grandparents or be financially supported by an uncle. Further description of the importance of the family role to Indonesian people is provided in Appendix A.

Pregnancy changes a woman's role and status in the family, particularly when she has her first child. Indonesian culture values planned pregnancies more highly than unplanned pregnancies. Traditional ceremonies reflect the importance of pregnancy and birth within the community (Bratawidjaja, 2000; Natalia, 2005; Suryawati, 2007). Before

birth, for instance, in the seventh month of pregnancy, there is an important Javanese traditional ceremony named *Tingkeban* or *Mitoni*, (from the word “*pitu*”, meaning seven), during which the family, friends, and neighbours pray for the welfare of the pregnant woman and the unborn baby (Bratawidjaja, 2000; Natalia, 2005; Suryawati, 2007).

Childbirth is considered a sacred event for Indonesian people and many cultural beliefs and behaviours surround birth in Indonesia (Bratawidjaja, 2000; Natalia, 2005; Suryawati, 2007). One traditional family ceremony, named *Mendhem Ari-ari*, involves praying and taking care of the placenta after birth (Bratawidjaja, 2000; Suryawati, 2007). Family and community are involved and support the woman during this experience. Further description of *Tingkeban* and *Mendhem Ari-ari* ceremonies is provided in Appendix B.

With the birth of a child, a woman's role changes from being a wife to being a mother. The great appreciation of the role of mothers, honoured for having risked death to give life, is also reflected in Indonesia's calendar of celebration days. Unlike other cultures, Indonesia celebrates Mother's Day but not Father's Day.

A well-known Indonesian proverb is: *Surga berada di bawah telapak kaki Ibu*, which translates as ‘Heaven is under the sole of mother's foot’ (Astini, 2015; Lubis, 2018). This means that even though a child is also afforded high status in Indonesian society, he or she is still positioned beneath the lowest point of the mother's body (Lubis, 2018). This proverb, considered to derive from Islamic thought, is used to show that people should be respectful of their own mother because of the difficulties and risks that childbearing involves for women.

1.5 Indonesia – Childbirth Arrangements

Indonesian women may give birth in a hospital, a maternity centre, a public health centre, a private midwifery practice or at home, particularly in villages, with help from traditional birth attendants, called *dukun bayi* (Anggorodi, 2009; Maas, 2004). A women's economic status usually determines her childbirth options.

Indonesian hospitals may be run by the government, army, police, religious orders or businesses. Surabaya for instance has 51 hospitals. These include, among others, the Dr. Soetomo Public Hospital, the Dr. Ramelan Navy Hospital, the Local Police Hospital, several faith-based hospitals such as St. Vincentius a Paulo Catholic Hospital, William Booth Hospital (Salvation Army) and the Islam Hospital, and private hospitals such as Surabaya International Hospital, Adi Husada Hospital and Siloam International Hospital (Pemerintah Kota Surabaya, 2018). These major hospitals provide a wide range of health services, including access to specialist doctors and diagnostic testing.

The women from middle to high economic status usually go to a hospital and see a doctor. This group may have more options to give birth and may even request a caesarean birth for non-medical reasons.

As the cost of accessing hospital services can be very expensive, some hospitals have clinics and maternity centres that offer more affordable care. Pregnant women attending maternity centres or health care centres are usually from a middle or low economic level. These women cannot request caesarean births for non-medical reasons, must rely on midwives' advice, and must follow instructions given by the midwives and the doctors. Pain relief, particularly in maternal clinics, is also decided by the doctors, and cannot be requested by the women. These women typically perceive themselves to be

“*tiyang alit*” and, as Satoto (2004) noted, are reluctant and very unlikely to complain even when they are not satisfied with the care provided by health care staff.

In 2011, the Indonesian government introduced *Jampersal* (short for *jaminan persalinan*), a childbirth insurance/guarantee scheme. *Jampersal* funding targets pregnant women, birthing women, post-partum women (until 42 days after giving birth) and newborns (0-28 days) and provides cover for basic care: four check-ups during pregnancy, normal childbirth, three normal post-partum services, and newborn services. These services are provided at *puskesmas*, *puskesmas mampu PONED* (short for *Pelayanan Obstetrik Neonatal Emergensi Dasar*, which are the public health centres providing basic emergency neonatal obstetric service), and other networks including *polindes* (short for *pondok bersalin desa* or village childbirth cottage) or *poskesdes* (short for *pos kesehatan desa* or village health station), and other private health facilities which involve cooperation with the government. In Surabaya alone, there are 63 *Puskesmas* (short for *pusat kesehatan masyarakat* or public health centres).

Many pregnant women who are aware of the poor service provided by the health centres prefer not to take advantage of the *Jampersal* system and opt to pay to go to maternity centres. An example of the poor service provided by the health centres as in stated in one of the participants in Rachmawati’s study (2004) whose her sister in law, a pregnant woman, was dead before surgery:

Sak ngertos kula mboten dipendet darahe, wong kula takon teng Mar, “Mar kowe dijukut darahe durung, wong arep dioperasi tuli dikir darahe”, “Ora ko, urung mbokan”, kados niku ngertos-ngertos teng wadahe darah niku tulisane O [Sepengetahuan saya tidak diambil darahnya, soalnya saya bertanya kepada Mar,

“Mar kamu diambil darahnya belum, soalnya akan operasi seharusnya ditest dulu”, “Tidak, belum mungkin”, begitu. Nah terus dibawa ke rumah sakit mau operasi. Tahu-tahu itu di tempat darah tertulis O] (Lily, Ipar 102, Kalimantan]

[As long as I know the blood was not taken, because I asked Mar, “Mar have they taken your blood, because before surgery it should be blood test”, “No, it may be not yet”, she said. After that she was brought to the hospital for surgery. Then suddenly in the blood pack stated O] (Lily, sister in law 102, Kalimantan] (p. 124)

If the results of the women’s pregnancy check-ups at the hospital are satisfactory, some of these women then opt to use *Jampersal* when giving birth.

An Indonesian hospital’s childbirth room usually consists of three to five small childbirth chambers separated by curtains in one big room (Figure 5). This arrangement means women can hear sounds from other chambers including screams, cries, and loud voices. Walls are bare and women are not encouraged or assisted to listen to recordings of relaxing music and sounds.



Figure 5. The childbirth chambers in a shared childbirth room in St. Vincentius a Paulo Maternity Centre, Surabaya, Indonesia

This arrangement makes it easy for one midwife to attend women in two or more chambers.

To become a midwife in Indonesia, the Indonesian Ministry of Health Regulation in 2017 stipulate a minimum of three years tertiary education (Menteri Kesehatan Republik Indonesia, 2017). The Indonesian Midwives Association defines a midwife as a female graduate from midwifery education accredited by government and relevant professional organisation in the area of the Republic of Indonesia with competency and qualification to be registered, certified, and or have a valid licence to engage in midwifery practice (Ikatan Bidan Indonesia, 2016). An Indonesian midwife's registration and certification lasts five years and can be renewed as long as the midwife continues to fulfil all the requirements of that role.

Continuity of care by the same midwife cannot be guaranteed for women enduring long labours. Typically, more midwives are rostered on for morning shifts and fewer on evening and night shifts. Unnecessary and avoidable demands on a midwife's attention, such as asking information about the labour duration or asking help if need something, inevitably impact the amount of time and attention she can give to each woman in her care.

I first addressed the practice of preventing family members or other support persons from entering the childbirth room during labour and childbirth in informal discussions with midwives at the *Pertemuan Ilmiah Tahunan Bidan I* (The First Indonesian Midwives Association Annual Scientific Meeting) held by Ikatan Bidan Indonesia (Indonesian Midwives Association) on 28-30 November 2014 in Bekasi, West Java. The midwives suggested this practice simply reflected their concerns that family members or other support persons might engage in undesirable behaviours in the childbirth room (such as panicking or fainting). The underlying consideration was that midwives assisting women giving birth should not be disturbed by a possible panic situation.

The prevalence of this practice in Arab countries (Kabakian- Khasholian, El- Nemer, & Bashour, 2015) suggests religion may have some influence on this practice. My other informal communication with the midwives having more than 20 years of maternity centre experience suggested a privacy consideration may also underpin this practice of not allowing laypersons to be present. With only the midwives and health care staff in the childbirth room, the women's privacy can still be guaranteed even where the curtains do not fully shield the birth chamber. If other people such as the women's

family members, or the husbands of other women were allowed to enter the childbirth room, the privacy of women in adjacent chambers could not be guaranteed.

1.6 The Researcher

My own knowledge of Indonesia and Javanese culture reflects my lived experience as an Indonesian woman and a long-term resident of Java, who has lived and worked in Surabaya for many years. My interest in this specific research topic derives not from any personal experience of pregnancy and giving birth, but rather from my training and research interests as a psychologist.

As a clinical psychologist and an Associate Professor in the Faculty of Psychology, University of Surabaya, I have learned many lessons from the subjects I have taught, (in particular, cognitive psychology (perception), psychodiagnostic (observation), counseling (communication skills), and humanistic therapy), clients' cases, cases I have supervised, and research I have conducted on pregnant women and newborns since 1993.

My Bachelor research investigated The Influence of Soothing Music on the Emotion of Newborns. Based on this research, my supervisor, the well-known Neonatologist Professor Emeritus Erwin Sarwono, advised me to investigate The Influence of Preferred Music on the Anxiety of Pregnant Women in Indonesia for my Master degree. A previous study on the influence of preferred music on the anxiety of pregnant women in Indonesia found that music had no significant meaning on the anxiety of Indonesian women during pregnancy (Natalia, 2005). It did, however, show that women's state anxiety declined at points coinciding with the group meeting times where

they received support from other pregnant women. This work primed my interest in the importance of support during pregnancy and childbirth for Indonesian women.

While collecting data for my previous studies (Natalia, 1998, 2000, 2008), I was allowed to enter clinical spaces in the maternity departments at the hospital and maternity centre, and I observed different midwives', women's, and family's perspectives on labour and childbirth. As a psychologist, I am particularly interested in the role that the intrapartum presence of a known, trusted support person can play in the management of anxiety and the perception and management of pain.

1.7 Research Questions

As this chapter has shown, clinical support is given to Indonesian women, and more specifically Javanese women, before and after birth. There is, however, a “missing link” with respect to support for women across the childbearing trajectory, and that is support during labour and childbirth. This study investigates that gap and the role that the intrapartum presence of a known, trusted support person can play in the management of anxiety and the perception and management of pain.

This study aimed to obtain a clearer picture about the perceptions of support during labour and childbirth in Indonesia in order to contribute to policy and practice for all who are involved in this area: the women, the support persons, the midwives and other health care staff. The overall question to be addressed by this study was ‘What are the perceptions of Indonesian (Javanese) women, their support person and midwives within the context of having a known, trusted support person present during labour and birth?’

The fact that this study explores the experience of midwives provides a new contribution to midwifery practice in Indonesia, particularly those within the Javanese culture. The aim of the study was to provide the first reliable report about support during labour and childbirth in Indonesia by using robust qualitative methodological processes.

The next section outlines the chapters of this thesis showing how it employs a biopsychosocial lens to address the research question.

1.8 Chapter Outline

The thesis consists of six chapters. Chapter 1 has introduced the topic of interest and provided the context and broad rationale for the study.

Chapter 2 presents a detailed review of the literature to highlight the gap in knowledge that this study addresses. It considers studies examining women's experiences related to labour and birth in Western countries and in Eastern countries including Indonesia. It reviews the theoretical frameworks afforded by health psychology, cognitive psychology, and existential and humanistic approaches, which can aid understanding of women's experiences during labour and birth and the support they need, and the perspectives of women, support persons and midwives.

Chapter 3 describes the study methodology and methods. This study used a naturalistic approach to answer the research question and narrative inquiry as the process of investigation.

Chapter 4 presents the findings, beginning with the demographic details of the participants followed by a description of the women's stories and themes and sub-themes

about the perceptions of the women, support persons, and midwives relating to women's labour and birth experience.

Chapter 5 presents a discussion of the findings, highlighting those that may be unique to the Indonesian community.

Chapter 6 provides the conclusion and considers the significance and potential impact of this study as well as describing its limitations. It offers recommendations that may benefit birthing women, their support persons, and midwives.

1.9 Summary

Based on the rationale provided, this study aimed to examine women's birth experiences when a known and trusted person accompanied them during childbirth. In addition, this study also sought to provide a multi-dimensional understanding of the phenomenon by examining the experiences of support persons and midwives caring for women during childbirth in order. No "whole picture" about support during labour and childbirth in Indonesia has been reported previously.

The next chapter highlights the gap in the existing knowledge that provided the focus for this study and describes the theoretical frameworks used in this research. It concludes with the detailed research questions.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter provides a literature review of the robust body of work on anxiety, emotional support, childbirth and the impact of these on each other. It highlights gaps in knowledge about the experience of having a known, trusted support person present during labour and birth.

The literature review begins by exploring how health psychology theory can be used to interpret women's experiences during labour and birth through a biopsychosocial lens. This is followed by an exploration of cognitive psychology theory, particularly as regards perception, and existential and humanistic psychology theory. It then reviews research relating to women's experiences of labour and birth in Western and Eastern countries, particularly Indonesia, where this study was conducted.

The search was conducted using phrases in English and *Bahasa Indonesia* that were developed from the research questions, for example: 'women giving birth', 'women's expectations of childbirth', 'anxiety / women giving birth', 'fear of childbirth', 'perception of childbirth', 'childbirth pain perceptions', 'support persons during childbirth', 'fathers expectation of childbirth', 'support person's experience of childbirth', 'doula', '*pendamping persalinan*', '*kecemasan selama bersalin*'. No date parameters were applied, and only papers written in English and *Bahasa Indonesia* were

included. Fifty-one papers written in English (published 1956 – 2019) were included in the review as well as 32 written in *Bahasa Indonesia* (published 1995 – 2017).

2.2 Health Psychology

As Taylor (2003) stated, “Health psychology is devoted to understanding psychological influences on how people stay healthy, why they become ill, and how they respond when they do get ill” (p. 3). Friedman (2011) provided a broader definition of health psychology as “*the scientific study of psychological processes related to health and health care*” (p. 12). In the professional arena, Friedman (2011) defined health psychology as “*the use of findings from basic psychological theory and peer-reviewed research to understand and encourage thoughts, feelings, and behaviours that promote health*” (p. 12). Morrison and Bennett (2012) offered a similar definition of health psychology as “the study of health, illness and health-care practices (professional and personal)” (p. 25).

Sarafino and Smith (2011) highlighted the long history of health psychology. Ancient people’s beliefs that mystical forces produced physical or mental illness can be inferred from discoveries of ancient skulls with holes that appear to have been attempts to release a bad spirit (Sarafino & Smith, 2011).

According to Sarafino and Smith (2011), between 500 and 300 B.C. Hippocrates, “the Father of Medicine”, introduced the idea of humoral theory. Convinced that illness was caused by the imbalance of the fluid in the individual’s body, he proposed dietary changes to rebalance the body. Later, Plato and Galen also explored mind and body

relationships. While Plato was convinced of the separation between mind and body, Galen held that illness could be localized in the brain, circulatory system, or kidneys.

Sarafino and Smith (2011) commented that “By the 1970s, physiological psychologists had clearly shown that psychological events – particularly emotions – influence bodily functions, such as blood pressure” (p. 10). Studies of how perceptual processes influenced the physiological processes within the individual’s body were significant in helping to more explicitly explain the relationships between mind and body so that more appropriate treatment could be provided. The development of cognitive behavioural therapy methods helped people to identify and change their erroneous beliefs. The use of relaxation techniques to reduce the degree of pain, depression, and change perceptions about pain gained more widespread acceptance (Sarafino & Smith, 2011).

In the mid-1970s, psychiatrist George L. Engel offered, as an alternative to the prevailing biomedical model, the biopsychosocial model, which held that biological, psychological, and social factors influence and are influenced by an individual’s health (Sarafino & Smith, 2011). The biopsychosocial model holds that clinicians must attend simultaneously to the biological, psychological, and social dimensions of illness in order to adequately understand and respond to patients’ suffering, while giving those patients a sense of being understood (Borrell-Carrió, Suchman, & Epstein, 2004).

While this biopsychosocial model appears highly applicable to childbirth, a complex phenomenon that needs to be understood from different points of view, Saxbe (2017) regards the experience of childbearing as under-researched with respect to the biopsychosocial model. Childbirth has biological, psychological, social and cultural

contextual aspects. Rather than simply adding a new family member, childbirth impacts the whole of a family's life, including each member's health (Saxbe, 2017). This biopsychosocial model of childbirth thus differs markedly from the purely biological perspective on childbirth discussed in the next section.

2.2.1 Biological perspective on childbirth

The childbirth experience is, in part, a biological process, and the biological perspective tends to focus on the physical systems of an individual's body. After fertilisation of a human egg, an embryo starts to grow and after 38 to 40 weeks of gestation this embryo becomes a full term foetus (Perry, Hockenberry, Lowdermilk, & Wilson, 2010).

Five factors, called the '5 Ps', influence labour and childbirth: the passenger (baby and placenta), the passageway (birth canal), the powers (contractions), the position of the mother, and her psychological condition (Perry et al., 2010). This section discusses only the first 4 Ps while the next section discusses the 5th P, the psychological condition.

The 'passenger' is the unborn baby. Its passage through the birth canal depends on the size and malleability of its head, its lie, its presentation, its attitude, and its position. The size and relative hardness and stiffness of the baby's head can have a big impact on the birth process. According to Perry et al. (2010), in about 96% of childbirths, the head is the first part of the baby's body to emerge from the mother, while about 3% of childbirths involve a breech presentation, where the baby's buttocks or feet emerge first and in the remaining 1% of births the baby's shoulder emerges first.

‘Passageway’ consists of the mother’s rigid bony pelvis and the soft tissues of the cervix, pelvic floor, vagina, and introitus. The size and form of the pelvic canal determine the likelihood of the mother having a normal birth. According to Perry et al. (2010), the soft tissues play an important role during labour in terms of stimulating the vagina to dilate to accommodate the unborn baby to be born and pushing the unborn baby against the cervix.

The beginning of labour depends on many factors and involves the maternal uterus, cervix, and hormones. Hormones produced by the unborn baby’s hypothalamus, pituitary gland, and adrenal cortex may initiate the labour process (Perry et al., 2010). Optimal levels of pituitary hormones for labour depend on low levels of catecholamines.

The hypothalamic-pituitary-adrenal (HPA) axis is responsible for the socio-emotional state of the mother. HPA produces corticotrophin-releasing hormone (CRH), which stimulates the pituitary gland to secrete adrenocorticotrophic hormone (ACTH), which activates the adrenal gland to produce the stress hormone, cortisol. Interactions between cortisol, the oxytocin system, and the endogenous opioid system seem to have an impact on the progression of labour, with high cortisol levels impairing the labour hormones (Saxbe, 2017). The woman is most likely, therefore, to go into labour when she is relaxed and feels secure (Perry et al., 2010; Saxbe, 2017). The presence of a trusted support person has been demonstrated to help reduce labouring women’s anxiety and induce and sustain a state of relaxation in the birthing mother (Chunuan et al., 2009; Dlugosz, 2013; Munir, 2011; Primasnia et al., 2013; Rahmy, 2013; Salehi, Fahami, & Beigi, 2016; Stiarti, 2011).

How a baby is born also depends on two ‘Powers’: involuntary (primary powers) and voluntary (secondary powers). Involuntary powers, known as contractions, occur automatically inside the uterus when the fetus is ready to be born and help move him/her towards the os uteri. When the baby is ready to be born, the midwife guides the mother to engage her voluntary ‘pushing’ powers to help the baby exit the uterus (Perry et al., 2010). Lay support persons are also able to provide this guidance by encouraging the women to follow the midwives’ guidance (Diponegoro & Hastuti, 2009).

‘Positions’ of the mother’s body also influence the labour process. A fatigued mother needs to find the most comfortable position for her body (Perry et al., 2010) and may need assistance to do this.

According to Perry et al. (2010), the labour of childbirth is usually completed in around 18 hours for a first-time mother and is usually spoken of in terms of four stages:

- the first stage extends from the first regular uterine contraction until the full dilation of the cervix,
- the second stage extends from the full cervical dilation until the baby is born,
- the third stage extends from the baby being born until the expulsion of the placenta,
- the fourth stage extends to around two hours after the placenta is expelled.

2.2.2 Psychological perspectives on childbirth

Women's perceptions of childbirth influence their feelings and behaviour during labour and childbirth. Perry et al. (2010) noted that while it is usual for women in some cultures to receive support and acceptance of their coping behaviours from their family or friends during childbirth, some women may feel shy about being vocally expressive in

the presence of their partner or even fear being scolded if they scream or cry during labour.

Women's expectations about childbirth also influence their feelings during childbirth (Macdonald & Johnson, 2017). Women who construct childbirth as a pleasant experience tend to feel more relaxed about it and in consequence their childbirth process tends to be easier (Macdonald & Johnson, 2017). Women with negative experiences of childbirth, or fears of childbirth may feel so stressed during labour that their catecholamine levels inhibit uterine contractions and slow the progress of labour (Perry et al., 2010). The later section on pain perception explores how women with a negative perception of childbirth tend to suffer more pain than those with more positive perceptions.

The relationship birthing women have with their midwives also influences the extent to which women experience pain, fatigue, anxiety, and embarrassment during labour (Macdonald & Johnson, 2017). Macdonald and Magill-Cuerden (2011) and Macdonald and Johnson (2017) identified trust, respect, and communication as the three key components underpinning good relationships between midwives and women.

Trust means that:

- midwives trust in their own ability to help the women give birth and this allows the women to feel safe with the midwives' help,
- midwives acknowledge, value and trust that women in their care have the ability to give birth successfully. Even midwives working under pressure are expected to compassionately serve women in labour, and

- the women have trust and confidence in their own ability to give birth successfully and this is bolstered by the midwives' trust in them.

The second component underlying a good midwife-woman relationship (Macdonald & Johnson, 2017; Macdonald & Magill-Cuerden, 2011) is respect. This is evident when midwives assure the women that they will provide care for them and will not harm them. This assurance helps to develop the women's trust as they become convinced that the midwives will provide good care for them.

The third component (Macdonald & Johnson, 2017; Macdonald & Magill-Cuerden, 2011) is communication, whether verbal and nonverbal (e.g., facial expressions, touch, gestures, silence, posture, space). Listening is an important aspect of effective communication. By listening and attending to women's feelings, midwives better understand those feelings and can build and/or maintain a good midwife-woman relationship (Macdonald & Johnson, 2017).

As well as the position, lie etc. of the fetus, a woman's readiness for labour is also influenced by her cognitive activity and emotional state (Wuitchik, Bakal, & Lipshitz, 1989). As noted earlier WHO (2017) recommends that women giving birth should be accompanied by a trusted person. Hodnett, Gates, Hofmeyr, Sakala and Weston (2011) hold that birthing women should be cared for in a quiet environment that is warm, and involves minimal cognitive stimulation or communication. As reducing distraction may help birthing women to focus more on the labour and childbirth process, birthing women may prefer their support person to communicate with them non-verbally rather than verbally. Hodnett et al. (2011) acknowledged that a low stimulus and warm environment

may be hard to realise in maternity centres in Indonesia, where non-airconditioned shared childbirth rooms may be both noisy and uncomfortably hot.

2.2.3 Social and cultural perspectives on childbirth

This section discusses social perspectives of childbirth in Indonesia, where childbirth traditionally occurs at home (Maas, 2004). Women giving birth at home are helped by traditional birth attendants, called *dukun bayi* (Anggorodi, 2009; Maas, 2004). These are usually older women who are well-known and respected in their villages for their considerable experience and expertise in the health area, especially in helping women give birth (Anggorodi, 2009).

As some communities wish to continue tradition and the local customs (Amilda, 2010; Anggorodi, 2009; Nuraeni & Purnamawati, 2012), this arrangement is still in place in some villages in Indonesia, particularly in remote areas that have little or no access to health facilities. Even in places with good access to health facilities, some women prefer the help of experienced *dukun bayi* rather than young midwives (Amilda, 2010; Anggorodi, 2009; Maas, 2004; Nuraeni & Purnamawati, 2012) for reasons described below.

Firstly, *dukun bayi* are also trusted to provide spiritual support (Anggorodi, 2009; Nuraeni & Purnamawati, 2012) and 40 days of postpartum care (Anggorodi, 2009; Maas, 2004; Nuraeni & Purnamawati, 2012). During this postpartum period, *dukun bayi* visit the women's house daily, provide support, and teach the women how to take care of their health and that of their baby (Anggorodi, 2009; Nuraeni & Purnamawati, 2012). *Dukun*

bayi also have a role in helping the women perform traditional ceremonies after childbirth (Anggorodi, 2009; Nuraeni & Purnamawati, 2012).

Secondly, *dukun bayi* cost much less than midwives (Amilda, 2010; Maas, 2004; Nuraeni & Purnamawati, 2012). Payments to *dukun bayi* can be made in instalments or if necessary in an alternative currency, such as rice (Nuraeni & Purnamawati, 2012). By comparison, midwifery care provides neither the wide range nor the duration of support that the *dukun bayi* do (Amilda, 2010; Anggorodi, 2009; Maas, 2004; Nuraeni & Purnamawati, 2012). These studies reporting Indonesian women's preferences for *dukun bayi* rather than midwives highlight women's recognition of their need for continuing support from the beginning of pregnancy until some weeks after giving birth.

As mentioned in Chapter 1, childbirth is considered a sanctified event for Indonesian people and Appendix B details traditional Javanese ceremonies relating to pregnancy and childbirth and the time after the birth.

2.3 Cognitive Psychology Approach – Perception

According to Sternberg and Sternberg (2012), "Cognitive psychology is the study of how people perceive, learn, remember, and think about information." (p. 3). Perception is, therefore, one of the key topics addressed by cognitive psychology. As shown in Figure 6, the perceptual process begins with a stimulus and ends with the conscious experience of perceiving, recognizing, and taking action regarding that stimulus, and is influenced by an individual's knowledge (Goldstein & Brockmole, 2017).

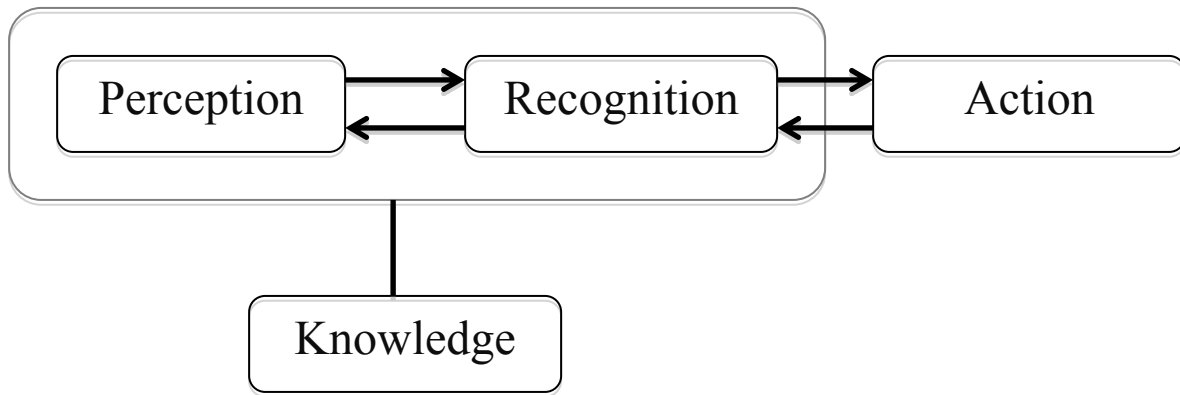


Figure 6. The perceptual process: perception, recognition, and action. Adapted from *Sensation and perception* by E. Bruce Goldstein and James R. Brockmole, 2017.

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According to Goldstein and Brockmole (2017), the perceptual process involves conscious awareness. The recognition process, which categorizes and gives meaning to a stimulus, is influenced by the individual's knowledge. The individual can then decide what action to take regarding the stimulus. This process is dynamic and continuously changing.

Goldstein and Brockmole (2017) reviewed a study conducted by Bugelski and Alampay (1961) which showed an ambiguous picture (Figure 7) to the participants. They asked the participants what they thought the picture was, a rat or a man.



Figure 7. The rat-man ambiguous picture used in Bugelski and Alampay's (1961) study. Adapted from "The role of frequency in developing perceptual sets", by B. R. Bugelski and Delia A. Alampay, 1961, *Canadian Journal of Experimental Psychology*, 15(4), p. 206. Copyright 1961 by American Psychological Association.

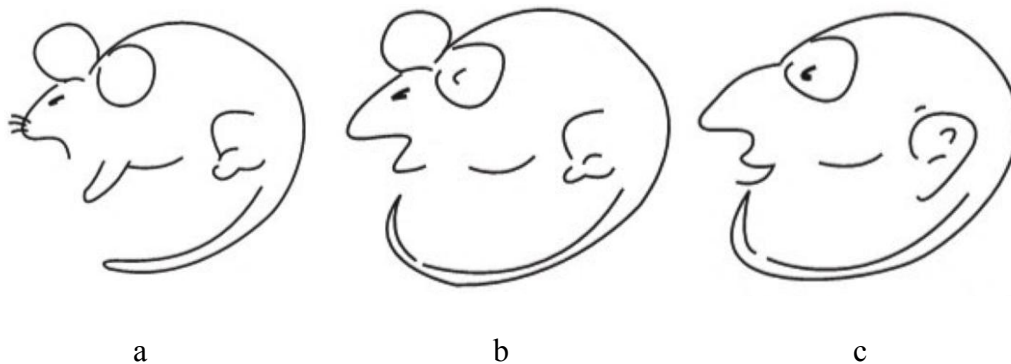


Figure 8. Left to right: a. the rat picture, b. the ambiguous picture, and c. the man picture. The rat (a) and man (c) picture adapted from "Sensation and perception", by Goldstein and Brockmole (2017). The ambiguous picture (b) adapted from "The role of frequency in developing perceptual sets", by Bugelski and Alampay (1961).

Figure 8 shows three pictures which were shown to the participants by Goldstein and Brockmole (2017). Based on Bugelski and Alampay's study (1961), Goldstein and Brockmole (2017) stated that people tended to see the ambiguous picture (b) as a rat after

people were shown the rat picture (a). On the other hand, people tended to see the ambiguous picture (b) as a man after people were shown the man picture (c).

From this study, Goldstein and Brockmole (2017) concluded that originally, the stimulus was neutral. It could be argued that a similar process occurs in a woman's perception of the childbirth process. Her perception, based on her prior knowledge, gives meaning to the stimulus, which results in it not being perceived as neutral anymore. For example, the woman may perceive the childbirth process as painful. This perception then influences how she responds to it, such as avoiding a normal childbirth process and requesting a caesarean childbirth.

2.3.1 Pain perception

As the pain of childbirth is one of the main sources of anxiety or fear among pregnant women (Handelzalts et al., 2015; Macdonald & Johnson, 2017; Matinnia et al., 2015; Rahmy, 2013; Reynolds, 1988; Ryding et al., 2015; Schetter & Tanner, 2012), it is important to explore the evolving understanding of pain and anxiety and how they are related.

According to the International Association for the Study of Pain (2018, Pain, para. 1), pain is "An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage". Pain is thus now acknowledged as a subjective experience, depending on an individual's physical and psychological state (Melzack & Katz, 2013; Merskey, 1991).

In 1895, Von Grey developed the specificity theory of pain based on the stimulus-response relationship (Ogden, 2007). According to him, the brain had specific areas

sensitive to specific stimulation such as touch, warmth, and pain (Ogden, 2007). In these early theories, psychology played no role because pain was viewed as a sensation only (Ogden, 2007).

Even in 1950s and early 1960s, pain was still regarded as a sensation (Goldstein & Brockmole, 2017; Ogden, 2007) and viewed through a biomedical lens as an automatic response to an external stimulus (Goldstein & Brockmole, 2017; Ogden, 2007). However, psychology played an important role in understanding pain in the twentieth century (Ogden, 2007).

Research has shown that individuals with similar degrees of injury react differently to pain (Ogden, 2007). Different responses have for instance been observed in American civilians and soldiers experiencing a similar degree of injury (Ogden, 2007). Eighty percent of the civilians requested medication to relieve pain compared to 25% of soldiers with the same degree of injury (Beecher, 1956). Some people still feel pain in a limb even after its amputation (Goldstein & Brockmole, 2017). Pain is, therefore, best regarded as not merely a sensation caused solely by the stimulation of the nerves in the skin, but rather as a perception (Ogden, 2007) involving activity in the brain (Goldstein & Brockmole, 2017).

Melzack and Wall's (1965) gate control theory of pain, summarised in Figure 9, explain some phenomena that could not be explained by the previous theories of pain. While Melzack and Wall believed this gate was located at the spinal cord, Goldstein and Brockmole (2017) located this gate more specifically in the spinal cord's dorsal horn. The strength of the information elements arriving at the gate determines whether the gate opens or closes.

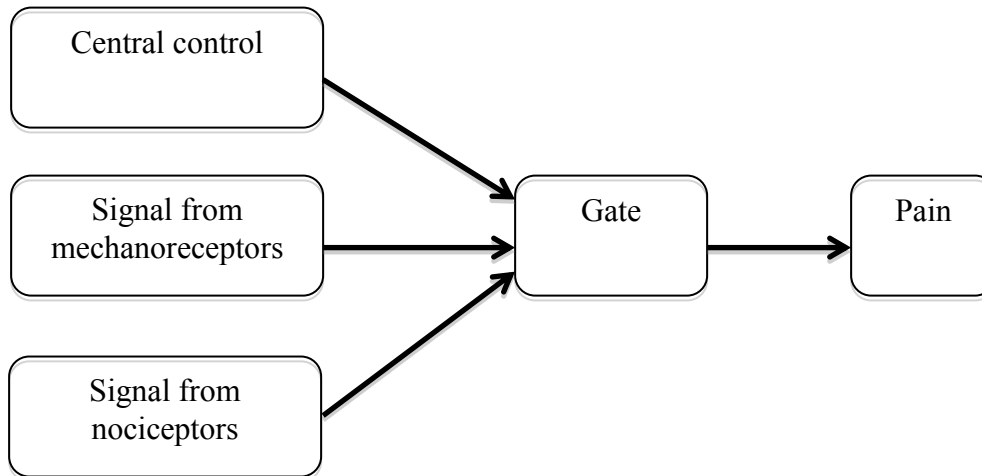


Figure 9. The gate control theory of pain. Adapted from “Sensation and perception” by Goldstein and Brockmole (2017).

The information is sent to the gate in three ways:

1. Signals from nociceptors bring pain information from the skin, such as heat, chemical, pressure, and cold.
2. Signals from mechanoreceptors bring non-pain information from the skin, such as massage and rubbing skin.
3. Central control brings information from the brain, such as expectation, attention, and emotion.

Recent research has found that psychological factors such as expectation, attention, and emotion also contribute to pain perception (Goldstein & Brockmole, 2017). Bingel et al. (2011) investigated the influence of expectation to pain perception by dividing 22 healthy volunteers treated with painful heat stimulation and the same dose of an analgesic into three groups given differing expectations: no expectation of analgesia, with expectation of positive effect of analgesia, and with negative effect of analgesia (expectation of increasing pain). The expectations were induced by verbal instruction and

strengthened by the conditioning-like procedure prior to the main experiment. Results showed that the pain rating was dropped to 39 in positive expectations of the drug's effectiveness, 55 in no expectations and increased to 64 in negative expectation. Based on this study, Bingel et al. (2011) concluded expectations influenced individuals' pain perception.

The perceived decrease of pain after taking a 'medication' with no active pharmacological ingredients is called the placebo effect (American Cancer Society, 2015; Goldstein & Brockmole, 2017). Individuals' beliefs that the substance can reduce their pain or heal them accounts for the placebo effect (American Cancer Society, 2015; Goldstein & Brockmole, 2017). This is often called the expectation effect, because the individuals expect something to happen in accordance with their expectations (American Cancer Society, 2015). Some individuals may feel better after visiting the doctor, simply because they trust that doctor and believe that doctor can heal their sickness (American Cancer Society, 2015).

To illustrate how attention influences an individual's pain perception, Goldstein and Brockmole (2017) recount the case of a five or six years old boy playing with Nintendo. When a dog pulled the wire off his device, he immediately tried to plug it back and in the process he banged his forehead against a radiator under the window. He was, however, so focused on continuing his game that he experienced no pain until he felt a wet sensation on his head and realized he was bleeding. Goldstein and Brockmole (2017) concluded that distraction could reduce an individual's pain if the individual did not focus or pay attention to the source of pain.

Many studies have shown that positive emotion is associated with pain reduction (Goldstein & Brockmole, 2017). deWied and Verbaten (2001) examined the influence of three types of pictures on the pain perception of male participants: positive pictures (sports and attractive females), neutral pictures (household objects, nature, people), and negative pictures (burn victims and accidents). They asked the participants to keep their hands in cold water (2°C) while viewing the pictures and only remove their hands when they felt pain. Results showed that the group viewing positive pictures kept their hands in the water longer (120 seconds) than the other groups (neutral pictures: 80 seconds, negative pictures: 70 seconds). deWied and Verbaten (2001) concluded that the types of pictures that stimulated the emotions of the participants influenced their pain perception. Positive emotions were associated with reduced pain perception (Goldstein & Brockmole, 2017).

Music has long been acknowledged as a powerful influence on human emotions (Altenmüller, Siggel, Mohammadi, Samii, & Münte, 2014). Many music therapy studies have shown the benefit of music played in surgical areas (Ayoub, Rizk, Yaacoub, Gaal, & Kain, 2005; Robb, Nichols, Rutan, Bishop, & Parker, 1995). Roy, Peretz, and Rainville (2008) examined the influence of silence, pleasant music, and unpleasant music on pain caused by a thermal stimulus presented to a participant's forearm. The intensity and unpleasantness of pain were measured by scales, which range from 0 (no pain) to 100 (extremely intense or extremely unpleasant). The results showed that pleasant music was associated with decreasing pain perception in its intensity and unpleasantness of pain (57.7 and 47.8) while silence (69.9 and 60.0) and unpleasant music (68.6 and 60.1) did not. This study showed that positive emotions were associated with a reduction in an

individual's pain perception (Goldstein & Brockmole, 2017). This suggests that music has the potential to provide a woman experiencing pain during labour and childbirth with some relief from pain.

As Dick-Read (1961) theorised, pain during labour is also influenced by fear, and in turn, by the tension that arises from fear. Fear, tension and pain associated with labour might be reduced by a distractor, a support person who might talk with them, particularly during labour, so that women have a different focus. The presence of a known and trusted support person beside a woman during labour and childbirth has been demonstrated to evoke positive emotions, and the distractive effect may be the reason why (Chunuan et al., 2009; Dlugosz, 2013; Munir, 2011; Primasnia et al., 2013; Rahmy, 2013; Salehi et al., 2016; Stiarti, 2011). Further, positive emotion has been demonstrated to reduce pain perception (Goldstein & Brockmole, 2017).

2.4 Existential and Humanistic Psychology Approaches

Every birth of a live baby means a new existence of a human being. However, paradoxically, the moment when life begins for the baby carries a perceived risk of death, symbolized as 'non-being', for the woman giving birth. Existential and humanistic models of psychology, which are concerned with this phenomenon, offer ways to understand the birth expectations and experiences of both the women and partner participants in the current study.

Existential and humanistic psychology attempt to answer the questions of human needs in the Age of Emptiness and these approaches are often considered jointly as Existential-Humanistic Psychology (Bugental & Bracke, 1992; Schneider & Krug, 2010).

As existential and humanistic psychology together afford a useful framework for considering the experiences of the participants in this study, the similarities and differences in these approaches are explored below.

2.4.1 The similarities of existential and humanistic psychology approaches

Existential and humanistic psychology are both rooted in phenomenology (Hoffman, 2006; Winston, 2015) and challenge the views that value objectivity when seeing phenomena (Hoffman, 2006; Winston, 2015). Existential and humanistic psychology argue that a purely objective view can never be reached as it is always contaminated by the subjectivity of the observer (Winston, 2015).

Both existential and humanistic psychology appraise the personal and subjective experience (Hoffman, 2006; Schneider & Krug, 2010; Winston, 2015). Both view humans as being subjects of their experiences and hold that understanding an individual requires an understanding of that individual's subjective experience and an effort to view the world as perceived by that individual (Hoffman, 2006; Schneider & Krug, 2010; Winston, 2015).

Both existential and humanistic psychology agree that a human being is free (Rogers, 2004; Schneider & Krug, 2010; Winston, 2015). Freedom is needed by an individual to grow in this life (Buscaglia, 1972; Rogers, 2004) and those human beings who are controlled by past or future experiences with meaning in their present world are considered not to be free (Hoffman, 2006; Rogers, 2004; Schneider & Krug, 2010; Winston, 2015). In order to have freedom, an individual should be aware of him/herself (Hoffman, 2006; Winston, 2015). Self-awareness enables people to be free from their

desires, their unconscious, and the control of the external world (Hoffman, 2006; Schneider & Krug, 2010).

Existential and humanistic psychology further propose that human beings are basically good (Rogers, 2004). They have self-potential to grow in their life (Rogers, 2004; Winston, 2015; Yalom, 2002). Positive relationships with others, demonstrated through acceptance of them, help people to grow and actualize their potency (Rogers, 2004; Winston, 2015; Yalom, 2002).

2.4.2 The differences between existential and humanistic psychology approaches

Despite the similarities discussed above, there are some key differences between existential and humanistic psychology. Existential psychology, for example, values the future and acknowledges that the future has meaning for life in the present. By contrast, humanistic psychology stresses the “here and now” experience of the present life as a paramount guidance for an individual’s behaviour (Winston, 2015).

Existential psychology is aware of human limitations, such as death being inevitable for every human being. Existential psychology expert, Yalom (Popova, 2018) even contends that life is meaningful, because it is limited by death. Humanistic psychology does not emphasize this issue of limitations (Hoffman, 2006; Winston, 2015).

Contemplation of death also helps people focus on the individuals and relationships most important to them. For example, in a study (Natalia & Pramadi, 2007) conducted in Indonesia, 170 Psychology students were given an individual closed envelope that could only be opened when they were alone and had at least 30 minutes spare time. On the outside of the envelope were the instructions “Write a reflection based

on the content of this envelope”. The enveloped contained only one small piece of paper that read “If I Must Die Tonight ...” Most of the students’ reflective writing focused on their expectation of being accompanied by their meaningful support person when they only have limited time left in their life, and have to face imminent death. A similar theme was also found by Naftali, Ranimpi, and Anwar (2017) in a qualitative study with six Indonesian elderly people that found that its participants expected to be accompanied by their family, or known and trusted people when facing death (Naftali et al., 2017). The majority of the participants in these studies expected to spend their very valuable limited time by being accompanied by a known, meaningful, and trusted support person when they thought and reflected about the closeness of their death (Naftali et al., 2017; Natalia & Pramadi, 2007).

Existential and humanistic psychology also differ on the motivators for growth. While existential psychology holds that anxiety can be constructive to a person’s life because it helps individuals to survive, humanistic psychology is interested in the human tendency towards actualizing as the energy for growth (May, 1969, 1977; Winston, 2015).

Existential psychology focuses on death, which symbolizes the limitation of life, but precisely because it makes life more meaningful, women who struggle with the childbirth experience are likely to benefit from having a support person beside them to strengthen them in this meaningful moment in their life.

2.4.3 Rogers' general law of interpersonal relationships

Regardless of the cultural context, anxiety is a common response to pregnancy (Larasati & Wibowo, 2012; Reading, 1983). In his article titled *The emergence of existential psychology*, May (1969) agreed with Kierkegaard (1944), who stated that essentially, anxiety (regardless of the practical cause) is the struggle of the living being against nonbeing.

To understand women's anxiety regarding labour and childbirth, it is necessary to consider what any human basic needs are. According to Buscaglia (1972), humans have physical needs (such as food, drink, and rest) and psychological needs (such as to be seen, listened to, and appreciated) that require fulfilment. He held that people tended to fulfil their physical needs more readily than their psychological needs whereas the psychological needs have to be addressed to help humans have healthy lives. Buscaglia (1972) by contrast held that the basic human needs are to love and to be loved and that people need to know that they are loved.

Gabriel Marcel, a French existentialist Roman Catholic philosopher, stated "Love is the source of both human community and individuality – the individual uniqueness of a human being is constituted by the results of relationships with others" (Potts, 2015). Human beings thus need others as a companion in their life's journey, particularly in the important moments of their life, such as childbearing.

The birth of each child is a unique event. As an event that cannot be repeated, it thus has a special meaning and value, particularly for the child's parents. Previous studies (Naftali et al., 2017; Natalia & Pramadi, 2007) have found that individuals opt to spend their limited, meaningful time with their closest and loved ones, perhaps their spouse or a

member of their nuclear family. The positive effect of companionship during other major life events has also been documented (Naftali et al., 2017; Natalia & Pramadi, 2007).

Figure 10 shows the personal space illustration based on E. T. Hall's theory that might be analogous to the level of closeness of human relationships in this study. In Hall's theory, the inner circle represents the closer human relationships while the wider circle represents less friendly relationships. The intimate space might be analogous to intimate relationships (e.g., spouse, parent, siblings), personal space might be analogous to the close relationships (e.g., extended families, best friends), social space might be analogous to more extended relationships (e.g., neighbours, classmates, colleagues), and public space might be analogous to anonymous relationships (e.g., people on the street).

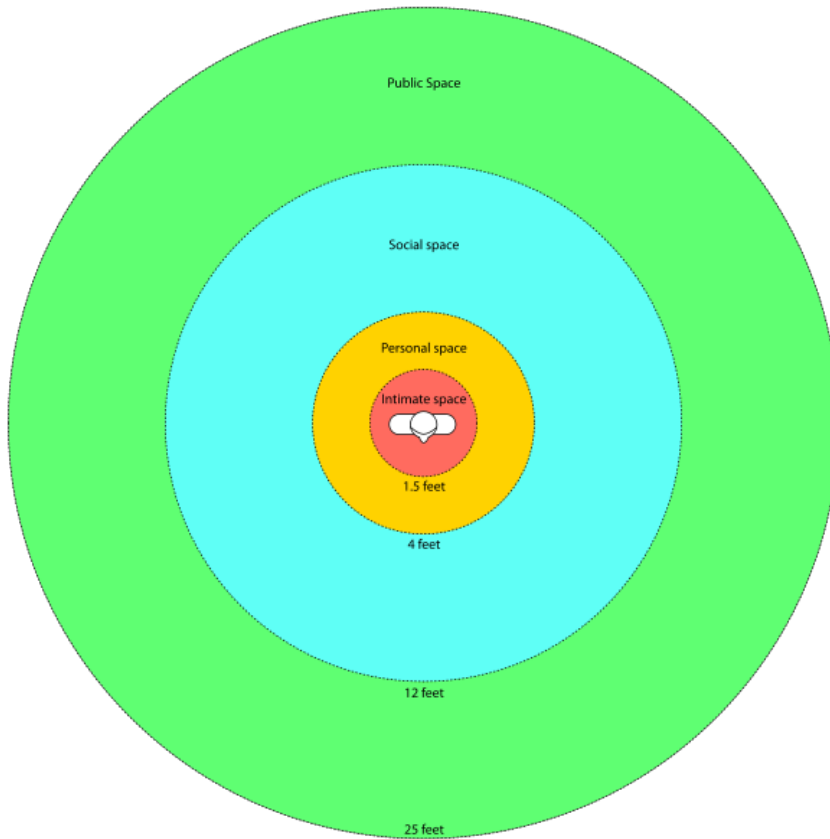


Figure 10. Personal space illustration based on E. T. Hall’s theory. Adapted from “E. T. Hall – Proxemics /Personal Space in Different Cultures” by laofutze.wordpress.com, 2016. Retrieved from <https://laofutze.files.wordpress.com/2014/01/personal-space.png>, 2014 Copyright 2014 by laofutze.wordpress.com

Aside from the health professionals attending her, it is unlikely that a birthing woman would want to have anyone other than a known and trusted support person present during the anxiety-provoking and painful process of labour and childbirth. The presence of a known and trusted support person can reassure the woman that she is not alone and that she is meaningful and valued. In this study, a known and trusted support person of the women in labour and childbirth was the closest person in an intimate relationship with the woman.

Rogers (2004), a famous humanistic expert, introduced client/personal centred therapy that can be applied to any type of interpersonal relationship. Figure 11 shows Roger's general law of interpersonal relationships, with trustworthiness depending on the attitude of the individuals a person interacts with and that individual's intention. Rogers' notion of therapeutic support may be applied to any type of relationship. This theory can thus illuminate the relationships of the individuals involved in the labour and childbirth experience, namely the birthing women, their support persons, and the midwives.

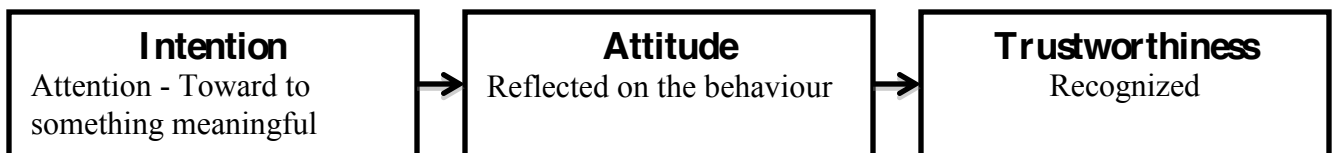


Figure 11. Roger's general law of interpersonal relationships.

An individual's intention and attitude as reflected in their behavior influences the perceived trustworthiness of that individual. May (1965) stated that intention consisted of *meaning* and *movement toward something*. Merleau-Ponty (May, 1965) held that an intention meant an attention to something. As the support during labour and childbirth involves the women and their support person, trustworthiness plays an important role in women' and support persons' relationships. The women should be able to recognize that the support persons can be trusted. The women recognize that the support persons can be trusted from the support person's behavior that fully attend to for the women, which means that the women are meaningful to the support persons, during labour and childbirth by understanding and fulfilling the women's needs.

Attitude plays an important role in human relationships. Rogers (2004) stated that in any type of relationship that allows individuals to grow, the helping relationship depends on the *attitude* of the person with whom the individuals interact. A positive or

negative attitude represents human intention towards something as well an overall disposition.

Rogers (2004) held that trust plays an important role in human relationships. Based on his studies and his experiences with clients, he found that successful therapeutic or helping relationships happened when therapists, counsellors, or parents showed that they were trusted and the clients or children perceived that the therapists, counsellors, or parents were trustworthy. He (Rogers, 2004) argued, “This (to me) pathetic incident would seem to indicate that even in a relationship to a machine, trustworthiness is important if the relationship is to be helpful.” (p. 46). May (1965) likewise held that trustworthiness is an important factor in a helping relationship.

Trustworthiness depends on the congruence of individual’s intention and attitude that reflects on their behaviour. According to Rogers (2004), congruence is one of the general laws of interpersonal relationships. It is important to therapy and all interpersonal interaction. Rogers (2004) stated, “Congruence is the term we have used to indicate an accurate matching of experiencing and awareness. It may be still further extended to cover a matching of experience, awareness, and communication” (p. 339).

Rogers used an infant’s behavior to illustrate how congruence is perceived. When an infant is hungry, its awareness of this experience at its physiological and visceral level seemed to match. It might communicate this dissatisfaction by crying. The infant is a unified person because its communication, awareness, and physiological level are in congruence (Rogers, 2004).

According to Rogers (2004), the genuineness of individuals plays an important role in a helping relationship, and other key characteristics of helping relationships are acceptance and understanding. In his book *on Becoming a Person* (2004) Rogers stated:

Acceptance does not mean much until it involves understanding. It is only as I *understand* the feelings and thoughts which seem so horrible to you, or so weak, or so sentimental, or so bizarre – it is only as I see them as you see them, and accept them and you, that you feel really free to explore all the hidden nooks and frightening crannies of your inner and often buried experience. This *freedom* is an important condition of the relationship. (p. 34)

According to Rogers (2004), the freedom included freedom from any evaluation because evaluations are always threatening. As Rogers (2004) stated:

Very closely related to this learning is a corollary that, *evaluation by others is not a guide for me*. The judgements of others, while they are to be listened to, and taken into account for what they are, can never be a guide for me. (p. 23)

One of the benefits of a relationship is that individuals may get support from others. The value of support is highlighted in Irvin D. Yalom's article titled *Be Supportive* (2002), which states, "One of the great values of obtaining intensive personal therapy is to experience for oneself the great value of positive support." (p. 13).

As Buscaglia (1972) held that humans are essentially social beings who need other people's support to grow, just as a human baby needs support from other people, including nurture from adults and relationships with its own peers throughout its life (Buscaglia, 1972). In his article *Forward to Love* (1972), Buscaglia stated, "A loving person recognizes needs. He needs people who care, someone who cares at least about

him, who truly sees and hears him. Again, perhaps just one person but someone who cares deeply. Sometimes it takes only one finger to mend a dike”. (p. 25). From Buscaglia’s perspective, a marriage is thus an affirmation of the human need for deep relationships. As Buscaglia (1972) said, the childbearing woman might need just one support person who truly understands and accompanies her during labour and childbirth. This support person can strengthen her to pass the labour and childbirth experience.

Chapman (1995) held that providing quality time to loved ones in family or couple relationships helps those loved ones to perceive that they are loved. Chapman (1995) explained that quality time occurs when an individual pays attention to someone without disruption. If real quality time in a family or couple relationships is thus when the person pays attention, towards to their loved ones that is meaningful to them, then a shared experience of childbirth could be a very special form of quality time for a woman and her designated support person.

Chapman (1995) also argued that, in a helping relationship, acts of service and being helpful, such as addressing others’ needs, also confirms that loved ones are loved. He continued that such behaviours confirm that individuals are unselfish, and put the needs of loved ones first (Chapman, 1995). This behaviour might reflect the individual’s attitude that might also reflect their positive intention to their loved ones.

Chapman (1995) also saw physical touch as an important way to express love. A baby who usually receives physical touch (e.g., kisses, hugs, and being held) has a healthier emotional life than those who receive very rare or no physical touch (Chapman, 1995). A recent study confirmed that touching by a partner strengthened the relationships within couples (Field, 2019).

These behaviours (touching, helping and spending quality time together) that express love would be perceived as a positive experience that stimulates positive emotions and so might distract from the pain suffered by women in labour and childbirth.

Although the anxiety associated with labour and childbirth is usually seen as undesirable, May's *The Meaning of Anxiety* (1977) contends that anxiety is useful and has a meaning. He (May, 1977) said that anxiety could be destructive but it could equally be constructive and stated:

The confrontation with anxiety can (note the word *can* and not *will*) relieve us from boredom, sharpen our sensitivity, and assure the presence of the tension that is necessary to preserve human existence. The presence of anxiety indicates vitality. Like fever, it testifies that a struggle is going on within the personality. So long as this struggle continues, a constructive solution is possible. When there is no longer any anxiety, the struggle is over and depression may ensue. This is why Kierkegaard held that anxiety is our "best teacher". He pointed out that whenever a new possibility emerged, anxiety would be there as well. These considerations point to a topic that has barely been touched in contemporary research – namely, the relation between anxiety on the one hand and creativity, originality, and intelligence on the other. (p. xiv-xv)

2.5 Women's Expectations regarding Childbirth

While no study about women's expectation during labour and childbirth has been reported in Indonesia, studies in other countries have investigated women's expectations regarding childbirth. These studies (Gibbins & Thomson, 2001; Gibson, 2014; Iravani,

Zarean, Janghorbani, & Bahrami, 2015) seemed to have a positive impact on their participants, perhaps because the women appreciated being listened to so that their experiences and expectations could be better understood.

The phenomenological qualitative study with eight women conducted by Gibbins and Thomson (2001) in Northern England found that women who described their expectations prior to giving birth felt in control during their labour and childbirth, were involved in making decisions, were supported by their spouse and midwives and had their expectations fulfilled during labour and childbirth.

A further study by Gibson (2014) in the United States of America involved 80 women, 40 of whom saw an obstetrician and a further 40 who saw midwives. While all the women stated that they expected pain management during labour and childbirth, those who saw the obstetrician expected non-pharmaceutical (relaxation technique) and medical pain relief (epidural analgesia) and those who saw the midwives expected non-pharmaceutical pain relief (relaxation technique) only. This study found that, even though these women could clearly describe their expectations to the obstetricians or midwives, some of their expectations could not be fulfilled for medical reasons.

Iravani et al. (2015) conducted a study titled 'Women's needs and expectations during normal labor and delivery' with 24 women in Iran. This study identified seven categories of needs (namely physiological, psychological, informational, social and relational, esteem, security, and medical needs) that women expected to be fulfilled. Similar to previous studies, women in Iran seemed be able to describe their expectations before labour and childbirth in order to be understood.

The women in these studies (Gibbins & Thomson, 2001; Gibson, 2014; Iravani et al., 2015) could describe their expectations before labour and childbirth. In contrast, regarding to different practice of childbirth in Indonesia, the women might not be able to discuss their expectation, particularly regarding to pain management, during labour and childbirth. Therefore, this study proposed to explore the women's expectation before labour and childbirth in order to understand their needs.

2.5.1 Anxiety, pain and childbirth

Women's psychological condition plays an important role in their expectations and experiences of childbirth experience. Understanding a woman's anxiety regarding childbirth can help to reduce it and thus their fear of childbirth (Macdonald & Johnson, 2017; Reynolds, 1988).

Researchers (Astutik & Sutriyani, 2017; Batbual, 2014; Defiany et al., 2013; Diponegoro & Hastuti, 2009; Primasnia et al., 2013; Rahmy, 2013; Reynolds, 1988; Ryding et al., 2015) have investigated anxiety and its impact on childbirth. Anxiety can be divided into two types, state and trait anxiety (Spielberger, 1979; Spielberger & Vagg, 1995). Spielberger (personal communication, July 29, 2005) said, "State anxiety is related to the intensity of negative feelings at a particular time, while trait anxiety relates to the frequency that negative feelings are generally experienced by an individual". Spielberger's (1979) description of state anxiety (S-Anxiety) was:

Stressor → Threat → S-Anxiety

[Note: The arrows indicate causality.]

According to Spielberger (1979), a stressor is an objective stimulus, while threat is an individual's perception of the stressor. "S-Anxiety is the intensity of the emotional reaction to the perception of threat" (Spielberger, personal communication, July 29, 2005). Thus the birthing process can be regarded as an objective stimulus, while a woman's perception of the birthing process as very painful and uncomfortable can constitute a threat.

According to Spielberger (1979) an individual's perception of a stressor as a threat stimulates the hypothalamus activating a complex series of neural and biochemical processes in the body. Activation of the autonomic nervous system by the hypothalamus leads the pituitary gland to release *adrenocorticotrophic hormone (ACTH)* to the blood. This causes the adrenal gland to release adrenalin and other biochemical substances that excite and stimulate various mechanisms in the body. For instance, the heart becomes more active to deliver more blood to the brain and muscles, respiration is faster and deeper to supply more oxygen, saliva and mucus are reduced, the air passage to the lungs becomes wider, and more perspiration is produced to cool the body. Muscle tension readies the body to react strongly.

When women in labour and childbirth experience stress, this stimulates the production of adrenalin hormone. This hormone causes the narrowing of blood vessels which reduces blood circulation, which brings oxygen to the uterus. As a consequence, uterine contractions are reduced, which may inhibit the childbirth process. This condition can increase the possibility of childbirth complications such as bleeding and infection, which in turn can increase the likelihood of maternal mortality.

Further, according to Spielberger (personal communication, July 29, 2005) pregnant women may “feel more intense state anxiety when they think about their pregnancy, and experience anxiety more frequently during pregnancy”. This suggests women’s state anxiety levels may increase during labour if they focus on potential difficulties such as enduring a long labour, experiencing a lack of support from the midwives, having a complicated or difficult childbirth process, and the possibility of giving birth to a baby with health problem. Cognitive-behavioural theory likewise holds that thoughts influence feelings and that people usually feel anxious because they perceive a stressor as a threat (Dobson, 2001).

Schetter and Tanner (2012) reviewed 11 studies concerned with anxiety, depression and stress in pregnancy and the implications for mothers, children, research, and clinical practice. They found that anxiety during pregnancy increased the chances of a birth being preterm and this had adverse implications for the neurodevelopment of the baby. In addition, state anxiety was found to influence the birth outcome.

Seven of the 11 reviewed studies showed state anxiety to be significantly related to the predicted gestational age and/or preterm birth (Schetter & Tanner, 2012). In broad terms, they found that pregnancy anxiety consists of fears about health and well-being of the baby, hospital care with respect to their health, and the parental or maternal role. Their study provided no clear explanation about the relationships between anxiety and preterm birth, but recommended further study to investigate issues such as pregnancy anxiety and models of stress on mothers and babies (Schetter & Tanner, 2012).

Via interviews and observation Rahmy (2013) studied the correlation between the level of anxiety and the ease of the childbirth process for 36 participants during their first

pregnancy in Banda Aceh, Indonesia. While the basis of the anxiety assessment in her study was not clear, she reported a significant inverse correlation between the level of anxiety and the ease of the childbirth process: of 23 participants with high to moderate anxiety only 7.7% had an uncomplicated childbirth, while for 13 participants with very low or no anxiety 92.3% had an uncomplicated birth. She recommended that health caregivers focus on reducing the anxiety of women giving birth, but did not state how this could be accomplished.

Batbual (2014) found *asphyxia neonatorum* caused by the anxiety of the mother was one of the main causes of infant mortality in East Nusa Tenggara, Indonesia. This anxiety increased the concentration of *catecholamines* in the mother's blood circulation, which also decreased blood circulation to the uterus. The impact was a reduction in blood circulation to the placenta and a reduction in uterine contraction. As a result, oxygen supply to the foetus was reduced and this was reflected in the foetus' weak heartbeat; the latter was measured as a low *Apgar score*. By articulating the connection between the mothers' anxiety and the newborns' low *Apgar score*, Batbual's study highlighted the importance of reducing the mother's anxiety.

A broader longitudinal cohort study of 6,422 women conducted by Ryding et al. (2015) examined the relationships between fear of childbirth and the likelihood of undergoing a Caesarean section in six European countries: Belgium, Iceland, Denmark, Estonia, Norway, and Sweden. Ryding et al. found that 11.3% of 3,189 primiparous women who suffered fear of childbirth chose to have caesarean births, while 10.9 % of 3,233 multiparous women suffering fear of childbirth chose caesarean births. A cross-sectional study (Matinnia et al., 2015) of 342 Iranian low-risk primigravida women

showed that 62.6% of those with pregnancy and birth-related fear tended to choose caesarean births rather than normal births. Such a choice is less apparent in Indonesia maternity centres because caesarean births are only permitted on medical grounds, with psychological problems not considered to constitute sufficient medical grounds.

Matinnia et al. (2015) also identified six main reasons for fear: 1. the process of labour and childbirth; 2. life and well-being of the baby; 3. competence and behaviour of maternity ward personnel; 4. the mother's capabilities and reactions; 5. becoming a parent and family life after birth; and, 6. general fear in pregnancy (Matinnia et al., 2015). The study also recommended further studies explore the social, cultural and maternity contexts, and perceptions about fear. A better understanding of these issues would enable health care providers to provide better services or interventions that will contribute to reducing the fear or anxiety experienced by women (Matinnia et al., 2015).

Handelzalts et al. (2015) used a questionnaire to gather data from 101 nulliparous women in Israel about their fears of childbirth on the first day they came to the birth ward of a health centre, and gathered a second set of data about fear of childbirth and some additional questions two days after the birth. These researchers also used data from the mothers' medical records. Their results showed a fear of childbirth pre-partum was negatively correlated with mode of childbirth and subjective experience about childbirth. The higher the fear of childbirth, the more negative the woman's subjective experience of childbirth. Fear of childbirth pre-partum was associated with a fear of childbirth post-partum and this in turn was associated with the duration of the second stage of labor. The longer the duration of this second stage, the higher the fear of childbirth post-partum.

Their study showed the long-lasting consequences of a fear of childbirth; that is, they did not end with the women giving birth, but even they still existed post-partum.

These studies highlight the importance of reducing women's anxiety or reducing the women's fear of childbirth in order to avoid negative consequences such as preterm birth (Schetter & Tanner, 2012), difficulties during the childbirth process (Rahmy, 2013), low *Apgar Scores* for the newborn (Rahmy, 2013), a high number of elective caesareans (Matinnia et al., 2015; Ryding et al., 2015), and fear of childbirth post-partum (Handelzalts et al., 2015).

2.6 Supporting Women during Labour and Childbirth

Recognition that anxiety or fear of childbirth has negative impacts on women and their babies has stimulated research on ways to assist women to feel relaxed during labour and childbirth. Phumdoung and Good (2003) studied the effect of music in reducing the sensation and distress of labour pain. 110 primiparas were divided into two groups: music and control. Fifty-five women in the music group listened to music for three hours during labour while 55 women in the control group had no music playing during labour. The results showed that women in the music group felt significantly less sensation and distress of pain compared to the control group. Women in the music group found that music helped them to relax and distracted them from the pain.

Tagore (2009) stated that music provided many positive influences during labour, particularly by helping women to maintain the rhythm of the contractions at the beginning of labour, divert them from pain during the childbirth process, and ease tensions during a caesarean operation. She reviewed a study by Chang and Chen from

Taiwan in 2005 that showed the benefit of music therapy for women who had a caesarean. Music reduced their anxiety and enhanced their enjoyment of the caesarean.

Field (2010) discussed massage during pregnancy and labour. She concluded that massage is the most common alternative therapy chosen by women during pregnancy and labour. It was recommended by 61% of them compared to acupuncture (45%), relaxation (43%), yoga (41%), and chiropractic therapies (37%). Field (2010) found that women who received labour massage experienced less depression, anxiety, and back pain. They were also found to be less likely to suffer from post partum depression. The women who received massage therapy also had fewer antenatal complications. The cortisol level in this group was also lower compared to those in the control group who did not receive massage therapy. The cortisol level of their newborns was also lower, possibly because of the lower cortisol level of the women. Women in this group also experienced less pain and shorter labour (3 hours less than the control group), and also required less medication. In addition, Field (2010) found that the women who received massage therapy had fewer premature childbirths and fewer low birthweight newborns. She concluded that massage therapy may increase vagal activity, and this is responsible for all of these other outcomes.

Spending their time during labour with their known, meaningful, and trusted support person is acknowledged to help women feel relaxed and peaceful as they labour (Astutik & Sutriyani, 2017; Baker, 2010; Defiany et al., 2013; Diponegoro & Hastuti, 2009; Kartini, 2011; Lailia & Nisa, 2015; Primasnia et al., 2013; Sari, 2010). Having a support person present during labour and childbirth thus appears to be a feasible, low cost

way of helping women manage anxiety, fear and pain during labour and childbirth and could potentially strengthen family bonding.

Many studies have now reported that support during labour and childbirth can reduce women's anxiety about the experience (Astutik & Sutriyani, 2017; Baker, 2010; Defiany et al., 2013; Diponegoro & Hastuti, 2009; Dlugosz, 2013; Johariyah et al., 2014; Kartini, 2011; Klaus et al., 1986; Lailia & Nisa, 2015; Primasnia et al., 2013; Reynolds, 1988; Sari, 2010; Sektiawan, 2010; Stiarti, 2011; Torres, 2015). However, to date, the way in which support persons affect this outcome has not been reported.

During labour, many women feel anxious (Macdonald & Johnson, 2017), and as previously considered, this may be because they think about the risk of death (May, 1969). The presence of a known and trusted support person, however, can make those who feel death is a possibility feel relaxed (Naftali et al., 2017; Natalia & Pramadi, 2007). Some studies that have examined support during labour and childbirth are described in the next section. As both the health psychology and the cognitive psychology approaches hold that a pleasant stimulus may evoke positive emotion which in turn is associated with reduced pain perception (Goldstein & Brockmole, 2017; Ogden, 2007), the presence of a known and trusted support person, which might be considered a to be a pleasant stimulus, might engender positive emotions that may reduce the women's pain perception during labour and childbirth.

A study in Guatemala examined the effect of providing a female supporter during labour (Klaus et al., 1986). Four hundred and seventeen normal primipara women were randomly allocated into two groups: accompanied and not accompanied by a female supporter. The results showed that 168 women who were accompanied by a female

supporter during labour had fewer caesarean sections and oxytocin augmentation compared to 249 unaccompanied women. The study recommended human support in the labour process but there was no information about the gender of the support person.

A study in Mexico reported by Langer et al. (1998) found that there were positive effects of support by a doula (female helper) during labour and childbirth on breastfeeding and the duration of labour. Seven hundred and twenty-four women participating in the study were randomly assigned to two groups: 361 women receiving an intervention by a doula and 363 women having routine care. Women in the intervention group were accompanied by a doula during labour, childbirth, and immediately after childbirth. The study showed that the frequency of exclusive breastfeeding one month after birth by women in the intervention group was higher than those in the control group. The researchers recommended psychosocial support during labour and immediately after childbirth as an effective way to promote breastfeeding.

Baker (2010) reviewed research literature about support during labour and childbirth and found that effective support during childbirth assisted women to give birth naturally. She identified two theoretical approaches with respect to this topic. One approach explained the positive aspects of support during childbirth that facilitated labour and birth, while the other theory explained the positive effects of support in reducing the stress response of women. She concluded that midwives should ideally understand a woman in order to help them feel relaxed and give birth easily, and act as a supportive companion for a woman during childbirth when no other support person is present.

A study reported by Longworth, Kingdon, and Cert (2011) and conducted in the UK was designed to explore the role of the husband in the childbirth room. The

qualitative study with 11 husbands found that they seemed be unsure about their role during labour and childbirth even though later some of them found that they had a more important role than they had expected (Longworth et al., 2011). Longworth et al.'s study (2011) recommended support from the midwives to help the husband find their role during labour and childbirth and in turn, help their wife during labour and childbirth. They recommended a preparation class for husbands to highlight their role as a father in order to provide significant support to the women.

A qualitative study of eight women in Australia by Dlugosz (2013) showed that the presence of a partner helped women during childbirth. The presence of the partner seemed to be the main support for those Australian women during childbirth as women perceived a high value in being accompanied by their husband. In interviews with the women, Dlugosz found five major themes: the importance of presence; emotional support; being accompanied; anticipation and knowledge; and emotional bonding. Dlugosz (2013) found that by being witnesses to the labour and childbirth, the husbands seemed to admire and respect their wife more. This admiration, in turn, increased the women's self-esteem. In addition, the presence of her husband during labour and childbirth gave the woman a sense that she, her husband, and the newborn were unified as a family. In her study, she confirmed that women felt a deeper connection with their husband after he had witnessed her bearing their baby, and reported that childbirth unified them as a family.

Another descriptive qualitative study by Poh, Koh, Seow, and Hong-GuHe (2014) conducted in Singapore, had similar findings. The study with 16 first-time fathers found a range of emotions in the fathers, from calm, happy and excited to shocked and worried

during pregnancy and childbirth. Support from the health care staff, by sharing information about how the fathers were expected to accompany the women, was found to help them prepare themselves better for facing the strange environment (Poh et al., 2014).

A study about support intrapartum was conducted in the USA by Torres (2015). Torres (2015) studied the perception of 17 women who used a paid doula and lactation consultant in the USA. Respondents reported that changes in society mean that the experience of bearing children has also changed. In the past, women gave birth at home in their villages or communities surrounded by their family, friends and neighbours who provided adequate emotional or social support. However, in more recent years, many women have moved to the city and far from their hometown where their families, friends, and neighbours live. They lack this support, particularly when they need them at the time of childbirth. Therefore, to substitute for this support, they agree to pay for a doula because the health care professionals do not have enough time to provide physical and emotional support to the women during and after they give birth.

Previous studies have also endorsed support during labour (Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017; WHO, 2015, 2016, 2017) because of its capacity to increase women's childbirth satisfaction. Most recently, Bohren et al.'s study (2017) of 15,858 women in 17 countries found that women with support during childbirth had positive feelings about the childbirth process. Despite the known advantages however, the World Health Organization has identified barriers to applying this recommendation. These include national or health care policies or practices that do not allow support persons to accompany women during labour and childbirth (WHO, 2016).

Bohren et al.'s study (2017) also affirmed the benefits of a known trusted support person intrapartum. These authors reviewed 26 studies from 17 countries (13 set in high-income settings and 13 set in middle-income countries). They found that continuous support from a known and trusted layperson for women during childbirth had positive outcomes: more spontaneous normal childbirth, positive feelings about the childbirth process, shorter duration of labour, fewer caesarean births or instrumental normal births, less local analgesia, fewer babies with a low five-minute Apgar score. They also found no negative effects resulted from the provision of support for women during childbirth

As in Indonesia, some Arab countries (Kabakian – Khasholian, 2015) still do not allow anyone other than health professionals to enter a childbirth room to support women during labour and childbirth in order to minimize the risk of disturbing the midwives' work. Despite several studies outlining the benefits of lay / non-clinical support women during labour and childbirth, there appears to be no research investigating the impact of this practice on midwifery work.

2.7 Indonesian Studies about Support during Labour and Childbirth

Because of different cultures and practices, recommendations from many of the studies about support during labour and childbirth are difficult to apply in Indonesia. Studies about support during labour and childbirth conducted in Indonesia have rarely used qualitative approaches and some have used poor methodologies. For example, many claims and recommendations are unreferenced, and comparisons are made from raw not weighted data.

Diponegoro and Hastuti (2009) reported a study of support during labour and childbirth and the influence of a husband's support on the duration of the childbirth process of primipara women in Yogyakarta, Indonesia. Seventy-eight primipara women participated in this study. They used an observation sheet to measure the duration of stage two of the childbirth. Thirty-nine women were supported by their husbands while thirty-nine women had support from people other than the husband, including the mother, the mother in law, a sister, a friend, or a neighbour. The results showed that the presence of the husband significantly contributed to shortening the duration of childbirth, but the study did not explore the nature of the support provided by the husbands or other persons. The study concluded that the husband was the most appropriate support person for the women to being guided by the midwives as the 'leaders' of the childbirth process (Diponegoro & Hastuti, 2009).

Kartini (2011) examined support during labour and childbirth and found a difference in the progress of labour between pregnant women who were accompanied and not accompanied by their husband while giving birth, with the former group labouring more effectively. Kartini (2011) was concerned about instances of a long childbirth process, which can elevate the maternal death rate and considered that a sense of powerlessness and a lack of psychological preparation in the birthing women contributed to a long birthing process. She found that stress increased glucose consumption, caused fatigue and catecholamine secretion and contraction.

Munir (2011) stated that besides physiological factors, psychological factors played an important role in a successful childbirth. She observed 30 pregnant women giving birth in midwives' private practices in Tuban, Indonesia. She found that two-thirds

of the women who suffered very high anxiety levels had a long childbirth process in the second stage, while only 1 of 15 (6.7%) and 1 of 12 (8.3%) who had moderate and low anxiety levels respectively had a long childbirth process. She suggested that support from family (particularly the husband) and good rapport with the midwife can decrease anxiety and lead to a smooth birth.

A study of the influence of participation in pregnancy gymnastic classes during the third trimester primigravidae on anxiety regarding childbirth was conducted in Indonesia by Larasati and Wibowo (2012). The Hamilton Rating Scale for Anxiety (HRSA) was given to 56 pregnant women who attended the pregnancy gymnastic class at the public health centre in Surabaya. The results revealed that pregnancy gymnastics, which included a relaxation technique, could reduce women's anxiety. Feeling relaxed may reduce a woman's anxiety and lead to a birth without complications (Larasati & Wibowo, 2012).

Another study about the relationship between a husband's support and the anxiety of primigravidae women in Ungaran, Central Java, Indonesia, was reported by Primasnia et al. (2013). Their study used a questionnaire on anxiety about labour and childbirth to collect the data. The results showed that 65.2% of 23 women who were accompanied by their husband did not feel anxious compared to 21.7% of 23 women who were not accompanied by their husband. Primasnia et al.'s study (2013) recommended the presence of the husband in the childbirth room.

Defiany et al. (2013) studied the influence of a labour companion on childbirth pain in women attending Margono Soekardjo Hospital in Purwokerto, Central Java, Indonesia. Thirty women participated in the study, 19 of whom were accompanied by a

family member or husband, and 11 women who were not. The result showed that the women who had a labour companion felt less childbirth pain compared to the women who did not. According to Guyton (1997) (as cited in Defiany et al., 2013), being accompanied by a family member during labour and childbirth fulfilled the women's psychological needs which influenced the limbic system. Guyton further suggested that the comfortable feeling that the women experienced caused neurons to secrete oxytocin hormone which stimulated uterine contraction. This contraction caused the birth of the baby.

Johariyah et al. (2014) reported a study conducted in Cilacap, Central Java which compared the duration of stage 2 labour of women who were accompanied by different support persons. They found that the husband was the most significant support person to accelerate the duration of stage 2 on primigravida women, being 4.7 times more effective compared to another family member, 5.4 times more effective compared to the traditional birth attendants, and 0.9 times more effective compared to having more than one support person. The duration of stage 2 labour in the women in Johariyah et al.'s study who were accompanied by their husbands was less than two hours.

Another study of the impact of the husband companion on the labour and childbirth process was conducted in Surabaya, East Java by Lailia and Nisa (2015). There were 61 women participants in this study. The ease of labour was observed with the aid of the partograph. The study showed that 29 of 34 women who were accompanied by their husband during labour and childbirth perceived they experienced an easier childbirth (not defined) compared to 7 of 27 women who were not. Lailia and Nisa advised that the presence of the husband played an important role for women during

labour and childbirth because this could influence the psychological states of the women. The husband listened to the woman's thoughts and feelings during contractions, assisted her with relaxation exercises, and touched her (stroking the woman's back) in order to comfort her and reduce her anxiety. The support from the husband helped to encourage comfortable, relaxed, and calm feelings in the women. This support could influence the women's strength to bear their baby (Lailia & Nisa, 2015).

A descriptive study by Astutik and Sutriyani (2017) explored the effects of pregnancy gymnastics, husband's support, and midwives' support on the anxiety of women during labour. Their study was conducted in Malang, East Java. Astutik and Sutriyani's study (2017) used observation and a questionnaire to collect data on 36 women. Results revealed that there was a significant correlation between the participation in pregnancy gymnastic class and the anxiety of pregnant women. Pregnancy gymnastics classes that included relaxation techniques could help the women to stabilize their emotions. There was also a significant correlation between the husband's support and the anxiety of the women. Their study demonstrated that the support from a husband, compared to the pregnancy gymnastics and the midwives' support, had the most significant impact on the women's anxiety. They concluded that husbands played an important role for the women during labour and childbirth because the husband was the closest person – the main supporter - to the woman. Their study demonstrated that the women needed the support from the closest person. The presence of the support person had a positive influence on the women. Astutik and Sutriyani's study (2017) demonstrated that, by the attendance of the support person, the women could share their

pain and the husband could give consolation to the women by holding their hand, motivating the women to be strong during labour and childbirth.

2.8 Javanese Values

In Javanese culture, sometimes to maintain harmony, Javanese people's behaviour contradicts its purpose (Endraswara, 2016; Suseno, 1996). An example of this contradictory behaviour was observed in Prawitasari's study (1995) which was concerned with understanding emotion through facial expression in different cultures in Indonesia. In her study, Prawitasari's Javanese participants tended to laugh even though they were telling or listening to a sad or negative story. As Blot (1992) stated, usually it is difficult for foreigners to understand Javanese people's covert behaviour.

2.9 Justification for the Study

Many studies have shown the benefits of providing a support person during labour and childbirth and the few studies about this topic conducted in Indonesia have usually only assessed the duration of the labour. The study conducted using narrative inquiry methodology that is reported in this thesis is, therefore, unique in:

- seeking to simultaneously explore experiences and stories of birthing women, their designated support person, and their midwives,
- adopting a biopsychosocial approach using health psychology, cognitive psychology (perception), and existential and humanistic psychology (human relationship) lenses.

Through these stories, it was expected that the "voices" of these women, who usually come from middle and lower socio-economic levels, could be heard, which will

lead to a greater understanding of their needs. In addition, the support persons' and midwives' stories were also taken into account to understand the "whole picture" of support during labour and childbirth in this study. These insights have the potential to lead to maternal health care services that better meet the needs of women, and result in improved birth outcomes.

As Connelly and Clandinin (2006) suggested three level of justification, this study was developed from :

1. Personal justification.

From a personal perspective, I am a Javanese woman, I have lived my whole life in Java, and I have intimate knowledge of the Javanese health care system. Although I do not have direct personal experience of childbearing, I have vicarious experience of it through family members, friends, acquaintances and colleagues, and have been privy to the wish of many that it was a more family-centred event. In addition, my bachelor research about newborn has led me to study life before birth which guided me to interact with pregnant women. I was so admired by how amazing the early life was prepared very well. I belief that by providing support to pregnant women we are preparing good family basis as early as life is begun.

2. Practical justification.

The study is justified from a practical (practice) perspective on the basis that best available evidence indisputably supports the presence of a lay support person intrapartum for the positive effect it has on a woman's birth experience and outcomes.

3. Social justification.

Finally, the social rationale for this research is found in the fact that a satisfying birth experience in which the woman felt supported and enabled is associated with positive short and long term outcomes for her, her baby and her whole family's functioning (Astutik & Sutriyani, 2017; Bohren M.A., Hofmeyr G.J., Sakala C., Fukuzawa R.K., & Cuthbert A., 2017; Johariyah et al., 2014; Langer et al., 1998; Torres, 2015; WHO, 2017, 2018).

2.10 Summary

This chapter reviewed previous research on anxiety, emotional support, childbirth and the impact of these on the each other. It highlighted gaps in knowledge about the experience of having a known, trusted support person present during labour and birth.

The literature review explored health psychology theory, cognitive psychology theory, and existential and humanistic psychology theory and their relevance to the biopsychosocial approach. It reviewed research relating to women's experiences of labour and birth in Western and Eastern countries, particularly Indonesia and highlighted the lack of a holistic description of the provision of support from a known and trusted person for women during labour and childbirth from the perspective of the women, their designated support persons and their midwives.

The study reported in the following chapters addresses a gap in the literature by using qualitative methods to develop a more comprehensive understanding of women's, support persons', and midwives' perceptions of their experience at an Indonesian

maternity centre. The methodology selected for this study, an approach known as narrative inquiry, is explained in the following chapter.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter presents the methodology of this study. It begins with a description of the study setting, followed by a comparison of positivist and naturalistic research paradigms. This is followed by a discussion of narrative inquiry, the approach chosen for this study, and a detailed description of the research processes.

3.2 Study Setting

Addressing the research questions required finding a maternity centre or hospital where the staff would be prepared to support and participate in the project. I needed a centre where I would be able to interview a reasonable number of birthing women, support persons and midwives. A major hospital in a large city seemed a good choice because women were likely to attend antenatal check-ups there, even if they later decided to give birth in a public health centre.

The setting chosen for this study was the Maternity Centre of St. Vincentius a Paulo, Surabaya, Indonesia. This hospital, established in 1925 and managed by Serva Spiritus Sancti (SSpS) Sisters who came from Steyl in The Netherlands, has developed into a large modern facility offering a 24-hour Emergency Service, a general poly-clinic, 11 specialist poly-clinics, and a maternity centre. As Table 1 shows, this maternity centre offers antenatal, perinatal, and postnatal care to a large number of Indonesian women in the Surabaya region.

Table 1

Number of Patient Check-ups at the Maternity Centre of St. Vincentius a Paulo Catholic Hospital, Surabaya in 2015 – 2016

| | 2015 | | | | 2016 | | | |
|--------------------|---------|---------|---------|---------|---------|---------|---------|---------|
| | Jan-Mar | Apr-Jun | Jul-Sep | Oct-Dec | Jan-Mar | Apr-Jun | Jul-Sep | Oct-Dec |
| Pregnancy check-up | 1562 | 1450 | 1166 | 1044 | 1035 | 1063 | 930 | 945 |
| Childbirth | 165 | 105 | 118 | 144 | 244 | 273 | 255 | 241 |
| Baby check-up | 604 | 542 | 516 | 524 | 516 | 452 | 577 | 442 |

The numbers for childbirth and baby check-ups are much lower than the numbers for pregnancy check-up, because women who are advised they can expect an uncomplicated birth tend to give birth at the free public health centres.

This Maternity Centre has such a good reputation that even though it is part of a Catholic hospital, many of its patients adhere to other religions. Some Muslim women told me that they prefer this maternity centre because its midwives' services are of such a high standard and its midwives are considered kinder, friendlier and more patient than midwives in Islamic hospitals. In some cases, the women's mothers and grandmothers had also given birth at this maternity centre.

The doctor who supervises this maternity centre has instructed its midwives to persuade women to have normal births whenever possible. As caesarean births are only permitted when a doctor has confirmed there are medical grounds to justify this procedure, neither the birthing women nor the midwives attending them can simply request that procedure.

3.3 Study Design

There are two frequently used scientific paradigms in which research is conducted: positivist and naturalistic (Denzin & Lincoln, 2018; Streubert & Carpenter, 2011; Tuli, 2010). Even though these approaches are different, both of them aim to find the truth and enrich the knowledge that we have, yet neither approach is considered better than the other (Streubert & Carpenter, 2011). The researcher's choice of approach depends on the research questions they propose to investigate (Streubert & Carpenter, 2011; Tuli, 2010).

The positivist paradigm sees the nature of reality as single, tangible, and fragmentable, with this single reality considered to be predictable and controllable (Lincoln & Guba, 1985). The positivist approach emphasises that researchers should maintain a high degree of objectivity (Denzin & Lincoln, 2018; Lincoln & Guba, 1985; Streubert & Carpenter, 2011; Tuli, 2010). Researchers working in the positivist paradigm see the relationship of knower to the known as independent (Lincoln & Guba, 1985). Researchers working in this paradigm maintain a distance from that which is researched to avoid bias in the results (Denzin & Lincoln, 2018; Streubert & Carpenter, 2011; Tuli, 2010). This approach makes use of quantitative methodology; specifically it uses measurements to gather data (Streubert & Carpenter, 2011; Tuli, 2010). Positivist scientists usually use numbers as their research data and analyse them with statistics (Streubert & Carpenter, 2011; Tuli, 2010). This approach is usually used in exact sciences or experimental studies, and in human studies such as psychology (Denzin & Lincoln, 2018; Streubert & Carpenter, 2011).

The positivist approach involves deductive thinking and its goal is to generalize the results to a population (Lincoln & Guba, 1985; Streubert & Carpenter, 2011). The positivist states that there are real causes, temporally precedent to or simultaneous with their effects (Lincoln & Guba, 1985). Researchers working in the positivist paradigm hold that inquiry can be value-free but argue about the possibility of generalization that can be time- and context-free (Lincoln & Guba, 1985). This reasoning leads positivist researchers to work with population samples comprising a large number of participants (Lincoln & Guba, 1985; Streubert & Carpenter, 2011).

By contrast, researchers working within the naturalistic approach tend to view the researched as a whole that cannot be separated into parts (Lincoln & Guba, 1985; Streubert & Carpenter, 2011; Tuli, 2010). The feelings of study participants are considered and the investigation attempts to understand these feelings from the participants' point of view (Denzin & Lincoln, 2018; Streubert & Carpenter, 2011; Tuli, 2010) in their natural settings (Denzin & Lincoln, 2018). According to this approach, and in contrast to the positivist 'one true reality' tenet, multiple realities exist and truth is relative and subjective because it depends on how individuals perceive the world and these perceptions vary from one person to another (Denzin & Lincoln, 2018; Lincoln & Guba, 1985; Streubert & Carpenter, 2011; Tuli, 2010). Realities are multiple, constructed, and holistic (Lincoln & Guba, 1985). A researcher in this paradigm, therefore, requires a mind open to the differences in the world (Streubert & Carpenter, 2011). The relationships of knower to the known are interactive and inseparable (Lincoln & Guba, 1985). Naturalistic researchers see that entities are in a state of mutual simultaneous shaping where it is impossible to distinguish causes from effects (Lincoln &

Guba, 1985). The naturalist also states that inquiry is value-bound (Lincoln & Guba, 1985). As quantitative measurement cannot fully explicate participants' points of view about a phenomenon of interest, naturalistic researchers employ qualitative methodologies.

Because my study investigated subjective experiences, I decided that adopting a qualitative methodology would enable me to more fully answer the research questions and gather more appropriate data than would be possible using a quantitative methodology. This choice meant I needed to be aware of and accept many realities rather than 'judging' the phenomena.

To remain close to the reality of its participants, my study adopted a naturalistic approach using natural and familiar settings (Denzin & Lincoln, 2018) such as the maternity centre already familiar to women attending it for check-ups, gymnastic classes, and antenatal classes and intending to give birth there.

3.3.1 Narrative inquiry

I chose to conduct this study using narrative inquiry, because it is an appropriate method for studying socially marginal participants, whose voices are rarely heard (Creswell, 2015), a category that includes the Indonesian childbearing women in this study. Narrative inquiry was initially used in educational settings (Clandinin & Connelly, 2000), but as John Dewey held, life is education, and educators are interested in life (Clandinin & Connelly, 2000). Clandinin and Connelly (2000) argued that educators learn life through values, attitudes, beliefs, social systems, institutions, and structures, and how these influence learning and teaching. According to Clandinin and Connelly

(2000), educational researchers learn about humans' lives through their experiences and due to the complexity of human experience, life cannot be understood by measurement alone. As Haydon and Riet's (2017) study demonstrated, use of narrative inquiry affords valuable insights regarding individual's experiences with respect to their health. Working with such insights enables health care centres to provide better service (Haydon & van der Riet, 2017). In this study, the birthing women and their designated support persons, and the midwives could all offer valuable insights that would enable the maternity centre to enhance the services it provides and the health of mothers and babies.

3.3.2 Philosophical basis

3.3.2.1 *Ontology*

Ontology explores the nature of reality (Creswell, 2013; Denzin & Lincoln, 2018; Tuli, 2010) and the ontology of narrative inquiry is that reality is subjective and multiple. These subjective and multiple realities might be viewed from the researchers', the readers', and the participants' points of view (Creswell, 2013; Lincoln & Guba, 1985; Streubert & Carpenter, 2011; Tuli, 2010).

Experience is the ontological basis of narrative inquiry (Clandinin & Connelly, 2000; Clandinin & Murphy, 2009; Clandinin & Rosiek, 2007; Creswell, 2013), according to the Deweyan Theory of Experience. Clandinin and Rosiek (2007) stated that "experience is the fundamental ontological category from which all inquiry – narrative or otherwise – proceeds" (p. 38). Dewey's ontology is transactional, not transcendental: experience is built from continuous interaction of human beings with the personal, the social, and the environment in contexts (Clandinin & Murphy, 2009; Clandinin & Rosiek,

2007). Based on Dewey's theory of experience, reality is understood as a relational, temporal, and continuous experience (Clandinin & Murphy, 2009).

My study aimed to understand support provided during labour and childbirth from three points of view (women, support persons, and midwives), based on their reciprocal interactions in each context, before, during, and after labour and childbirth. Based on Dewey's theory, my study, therefore, probed participants' experience, particularly the experiences of the women and their support persons, in chronological order (before, during, and after labour and childbirth) within reciprocal interactions among them, their society and environment, to understand each participant's point of view. My study also examined the experience of the midwives, who interacted with the birthing women and their support persons during labour and childbirth.

3.3.2.2 Epistemology

Epistemology explores the relationship between the researcher and that being researched (Creswell, 2013; Denzin & Lincoln, 2018; Tuli, 2010). The epistemological characteristic of narrative inquiry is that the researcher attempts to reduce the distance between himself or herself and those being researched. Researchers using narrative inquiry collaborate, and spend time in the field, with participants, and become "insiders" as far as possible (Creswell, 2013; Lincoln & Guba, 1985; Tuli, 2010).

How experience is understood depends on the extent of the trust between the researched and the researcher (Clandinin & Connelly, 2000; Creswell, 2015; Lincoln & Guba, 1985; Pinnegar & Daynes, 2007; Tuli, 2010). This relationship between the researcher and the researched plays an important role in narrative inquiry.

The researcher should be in an equal position to the researched. S/he should become part of the experience of the researched to understand the experience of being studied (Clandinin & Connelly, 2000; Creswell, 2015; Lincoln & Guba, 1985; Pinnegar & Daynes, 2007; Tuli, 2010). However, there is a dilemma with this position: some argue that if researchers become fully involved in the life of the researched, they can lose their objectivity (Clandinin & Connelly, 2000). On the other hand, researchers who remain at some distance from the researched will not fully understand the experience of being studied (Clandinin & Connelly, 2000).

Creswell (2013) stated that a qualitative researcher should try to be as close as possible to the participants in order to understand their point of view. That is the reason why the “field”, where the participants live and work, plays an important role in qualitative studies (Creswell, 2013). Experiencing the participants’ “field” permits the researcher to understand the participants’ context (Creswell, 2013).

By experiencing the participants’ daily lives, I attempted to understand and feel the participants’ experiences from their points of view. To minimize the distance between myself and the participants, I tried to experience the regular daily lives of people from the lower socio-economic classes by using public transport (Figures 12 to 14), shopping at traditional markets and stores that participants usually frequent, walking inside common “*kampung*” (a high density area comprising small houses in small lanes as seen in Figure 15 and 16) that are similar to participants housing areas, and visiting some participants’ houses (Figure 17 to 19).



Figure 12. Public transport station at Terminal Joyoboyo Surabaya, Indonesia.



Figure 13. Common public transport, *angkot*, in Surabaya, Indonesia.



Figure 14. A street performer entertains people waiting for the *angkot* to reach its full capacity (13 passengers). This can involve waiting an hour or more before the actual journey commences.



Figure 15. One of the participants' housing area in a *kampung*.



Figure 16. Another participant's housing area in a *kampung*.



Figure 17. One of the participants welcoming me to her house.



Figure 18. Me (on the left) visiting a participant's house.



Figure 19. Me (centre) visiting a participant's house.

In order to experience the maternity centre's atmosphere from the participant's perspective, I helped the maternity staff by guiding the women to the check-up room. I also observed the maternity centre's gymnastic classes attended by some of the participants (Figure 20).



Figure 20. One of the maternity centre's gymnastic classes held for pregnant women and run by one of the midwives

3.3.2.3 Axiology and reflexivity

Axiology refers to the role of value. In narrative inquiry, the researcher acknowledges that the study could be biased by the researcher's personal values. Because of this awareness, the researcher should disclose any of their own values that may influence the narrative (Creswell, 2013; Tuli, 2010). My own values are influenced by having grown up in Java, in a family influenced by Javanese values, Chinese values and Roman Catholic religious beliefs. My own values are also influenced by my school and

university education in Indonesia (undertaking a Bachelors Degree in Psychology in a private university to qualify as a psychologist), and by my experiences as a postgraduate student (undertaking a Masters Degree in Music Therapy and later a PhD) at Australian universities. My work as a lecturer and psychologist at the Faculty of Psychology, University of Surabaya also influences my values. My initial research interest in newborns leads me to study life before birth, during pregnancy. Many factors influence newborns, such as pregnant women's anxiety. Therefore, I am interested in findings ways to reduce women's anxiety so that they can provide a better milieu for their newborns.

While I had not personally experienced pregnancy or childbirth, I had observed birth when I completed my Bachelors study in 1993 and could draw on my previous research with pregnant women and their families. In addition, I had the opportunity to converse with midwives during my study since 1993 in the Dr. Soetomo public hospital and the St. Vincentius a Paulo Catholic hospital. I gained an appreciation of their workloads and their family and life experiences.

3.4 Methodology

Based on the ontology and epistemology described above, this study used the qualitative methodology of narrative inquiry. According to Pinnegar and Daynes (2007), Narrative Inquiry has four characteristics:

1. An equal and intimate relationship between the researcher and the researched.

In Narrative Inquiry, the participants tell their experience or life story, therefore, trust plays an important role. A researcher should, therefore, place him/herself on an equal level with the participant in order to engender trust in the participants. Pinnegar and

Daynes (2007) assert that the researcher should become the participants' friend and engender an intimate relationship that will enrich the lives of both participants and the researcher.

To demonstrate equality and become a friend, I placed seats in close proximity, and not separated by a table, whenever I interviewed the study participants (see Figure 21).



Figure 21. Seats in close proximity, and not separated by a table during interviews with participants.

2. Using words rather than numbers.

Narrative Inquiry is about telling the participants' story. This story is expressed through language but also through gesture/body language/emotion (see Figure 22).



Figure 22. Trying to understand a participant's gesture/body language/emotion.

3. Focus on the individual rather than the universal.

Understanding and focusing on each participant's story is more important than finding a large number of participants (see Figure 23).



Figure 23. Trying to understand and focus on a participant's story by attending and taking notes.

4. Open-mind to accept many possibilities about the truth.

Each participant is unique. Each has their own story that is different from others.

Therefore, the researcher should be aware of and open to many possibilities emerging from the participants' story and acknowledge and accept the multiple realities s/he hears about the phenomenon described in the interview (or 'topic').

There are a number of opinions about what that narrative should represent, for example Connelly and Clandinin (1990) stated that the researcher should consider time, place, plot and scene of the participants to build a good quality narrative. According to Clandinin and Connelly (Clandinin & Connelly, 2000; Creswell, 2015), there are three dimensional spaces of Narrative Structure: Interaction, Continuity and Situation.

1. Interaction: personal and social.

Individuals cannot be separated from their social context. This includes their culture, beliefs, and norms, which may affect how individuals make decisions. Researchers should, therefore, consider these factors in order to more fully understand the participants' points of view.

Narrative Inquiry highlights the important role of the interaction between personal and social factors. Because the Indonesian childbearing women participating in this study lived in a communal culture, it was important to understand how society influences them and how their trusted support person may influence their expectations and experiences of partner support in labour.

My study explored how Indonesian childbearing women birthing in a typical Indonesian maternity centre experience having a known, trusted support person with them during labour and birth. It was expected that a clearer picture of Indonesian women's perceptions about their support person, and the perceptions of the support person accompanying them during childbirth, would emerge by collecting data in the natural setting.

Figures 24 to 26 depict examples of social norms that I was aware of, and realised I would need to adopt to gain entry into participants' lives.



Figure 24. As greeting each other is a common custom in *kampung*, I greeted a local resident.



Figure 25. In accordance with language preferences in *kampung*, I used the *Javanese* traditional language to elicit directions to a participant's house from a local resident.



Figure 26. I also adopted the local custom of removing footwear before entering the participant's house.

2. Continuity: Past, present, and future.

Narrative Inquiry also looks carefully at the temporal connections between events (i.e., past, present, and future). In order to understand the expectations and experiences of having support during labour and birth, it is, therefore, important to understand how participants see the world today, how it is influenced by their experience in the past, and their hopes for the future. The researcher should, therefore, be well informed about the participants' hopes and their negative and successful experiences in order to better understand how they see the world today. In my study, I interviewed the participants before, during, and after labour to understand their past, their present, and their anticipated future experience.

3. Situation: Place.

Narrative Inquiry also looks carefully at the place in which the participants live or are interviewed. Different places could influence the stories of participants. Connelly and Clandinin (1990) state that 'scene' encompasses the place where the behaviour emerged, and that it could not be separated from its social and cultural context. The researcher should, therefore, be aware of the social and cultural context in order to better understand the participants' behaviour.

In narrative inquiry, restorying is important. According to Creswell (2015), however, there are three steps to restorying that are required for elements to be identified clearly :

1. The researcher transcribes the participants' interviews.
2. The researcher retranscribes the story of the participants and identifies the key parts of the story and gives codes to indicate setting (s), characters (c), and action (a).
3. The researcher reorganizes the story based on the codes applied into chronological order.

After restorying, the researcher codes the story for themes. It is common practice in qualitative studies to have around five to seven themes emerge from the interviews (Creswell, 2015).

Polkinghorne (Clandinin & Murphy, 2007) stated that there are two different ways to approach the narrative data: analysis of narrative and narrative analysis. There is a significant difference between them. First, analysis of narrative, which is commonly used in other forms of qualitative research, involves analysing the narrative from the

story to elements. This process categorizes the elements into sub-themes, and then themes. In contrast, narrative analysis involves examining the narrative from elements to the story. Narrative analysis synthesises elements and constructs a story. However, because in this stage the researcher is working with the story and people are more familiar with the term “analyse”, Polkinghorne retained the term “analysis” during this stage. The final result of a narrative analysis is a story.

After reaching a set of findings, the researcher should conduct a member checking exercise. Creswell (2015) defined member checking as: “A process in which the researcher asks one or more participants in the study to check the accuracy of the account.” (p. 267). Creswell (2015) stated that the researcher should show the findings of the study to the participants and ask them to identify any irrelevant or superfluous information.

Reflexivity occurs before and during data collection and analysis, and after the data analysis process is completed. Streubert and Carpenter (2011) defined reflexivity as: “The responsibility of researchers to examine their influence in all aspects of qualitative inquiry – self-reflection.” (p. 34). Creswell (2015) stated that as a researcher, we should *be reflexive*: aware of our role in the study, and our beliefs, values, assumptions, and biases. These influences may affect the results of the study. Therefore, the researcher should discuss these in the study in order to disclose their position to the reader.

In addition, Strauss and Corbin (2008) stated that during the study, particularly when collecting and analysing the data, researchers might feel disappointed, glad, sad, and experience many other emotions. These emotions might affect the researcher’s interpretation of the data. As a result, it is important to declare the researcher’s own

beliefs, values, assumptions, and biases so that the reader will understand the researcher's point of view.

3.5 Ethics approval

Besides receiving approval from the Human Research Ethics Committee of Edith Cowan University (number: 12779 – see Appendix D), Ethical Clearance was obtained from the St. Vincentius a Paulo Catholic Hospital, Surabaya, Indonesia (number: 306/SDM/XI/2015 – see Appendix C).

3.6 Identifying potential study participants

Studies using narrative inquiry methodology could capture and analyse one individual's narrative or those of more than one participants (Creswell, 2015). Because of the time-constrained period available for data collection (given this study was conducted for a time-limited doctoral degree) and because support persons would only be permitted to be present at uncomplicated vaginal births, the sample comprised pregnant women who:

- expected to give birth between April and December 2016,
- expected to have a normal birth (rather than caesarean birth),
- were predicted to have no antenatal or intrapartum medical complications, and
- were willing to have a known, trusted person support them during labour and childbirth.

Recruitment ceased when no new information was identified in participant interviews. This point is known as data saturation in qualitative research (Streubert & Carpenter, 2011).

3.7 Data Collection

I met the maternity centre's supervisor and the head of midwives at St. Vincentius a Paulo, Catholic Maternity Centre to discuss the study in the first week of March 2016. I then gave a presentation about my study to the midwives on Tuesday, 15 March 2016 at 2.00 – 3.00 pm when shifts were scheduled to change at the maternity centre. About thirty of the total of fifty midwives attended this presentation.

As well as informing the midwives about this study, my presentation session provided a good opportunity to introduce myself and build rapport with the midwives who would collaborate with me in the following months. I presented a short video I had made of that maternity centre in 2004. This video informed the junior midwives about the huge number of patients that their maternity centre had treated in the past and prompted some senior midwives to share stories of that time, laugh at themselves when they saw how young they looked in 2004 and mention that some of the midwives on the video had since retired. The session went well and achieved the goals planned.

Some of the senior midwives, who already knew me from my earlier research there in 1998 and 2004, highlighted the many changes at the maternity centre since that time. One notable change was that the number of patients was less than in the past. This may have been because the Indonesian government introduced *Jampersal* in 2011 (described in Chapter 1), and so many pregnant women who were predicted to have

uncomplicated vaginal births opted to give birth at the public health centre, thus reducing the number of the women giving birth at the hospital's maternity centre.

As check-ups for pregnant women at the maternity centre were scheduled for Mondays (for new patients), Wednesdays and Fridays at 7.00 – 11.00 am, I visited the maternity centre on Wednesday, 16 March 2016 to observe the activities there and decide on the best strategy to recruit participants. Some senior midwives suggested I inform potential participants about my study before they started their gymnastic classes, I also observed some of the gymnastic classes held on Wednesdays and Fridays.

Two weeks prior to gathering the data, I became a volunteer at the maternity centre to familiarise myself with the administrative procedures involved when pregnant women see their midwives. This enabled me to identify when I should invite the participants into the study without interrupting usual care.

3.7.1 Recruitment

On Wednesday, 30 March 2016 at 8.00 am, with the permission of the maternity centre, I addressed the gymnastic class (see Figure 20) while the pregnant women were waiting for their gymnastic instructor midwife. I introduced myself, informed them about my study and explained that participation in this study was voluntary. Anyone who agreed to participate was free to withdraw at any time without reason and without penalty. This study would not influence or reduce their right to attend the maternity centre and involved no additional cost to participants.

These recruitment efforts resulted in 10 - 15 pregnant women expressing interest in participating in the study. I asked those women to provide their contact details on an information sheet, so that I could contact them later.

I scheduled the interview dates to coincide with the women's check-up at the maternity centre and ensured that women due to give birth first were scheduled to be interviewed first. I then arranged for interviews to be held in the private room (see Figure 21 to 23) at the maternity centre.

On Wednesdays and Fridays, I went to the maternity centre before 7.00 am and while waiting for the pregnant women who had agreed to participate to this study, I helped the administration staff to prepare the medical record forms at the reception desk. Some pregnant women arrived at about 7.15 – 8.00 am so they could see the midwives for their pregnancy check-up before their gymnastic class. After the check-up, those women waited for the scheduled 8.00 am gymnastic class that in accordance with 'rubber time' (see Appendix E – Indonesian Customs) usually started around 8.10 – 8.40 am and ended an hour later.

It was thus difficult to interview women either prior to the gymnastic class or after the class as some women then had to rush off to work. As a result, these women often postponed their scheduled interview to a later time. This meant some women had to wait a long time to be interviewed.

As some pregnant women visited the maternity centre alone, I could not readily interview their support persons. As a result I had to ask the pregnant women about their support person's schedule, and when an interview could be arranged with their designated support person. Where their support person was not living or working in

Surabaya, the pregnant women agreed to participate and to pass on information about their support person's schedule as soon as possible. I waited for the information and interviewed the support persons when they came to the maternity centre.

The pregnant women or support persons sometimes cancelled their scheduled interviews suddenly, even on the day, because they cancelled their visit to the maternity centre. This meant I had to re-schedule several interviews, which posed further difficulties for some participants. Only one participant could be scheduled for a specific interview time, and the need to re-schedule the others, sometimes several times, caused me to miss opportunities to interview other potential participants.

The cancellation and re-scheduling issues experienced during my first months of data collection led me to change my strategy for recruiting potential participants. I found approaching women individually when they visited the maternity centre for their pregnancy check-up was more effective. It seemed that this more personalised approach built a better rapport and allowed me to give clearer information to the potential participants.

I invited the women from the maternity centre to participate in the study after they had seen the midwives for a routine pregnancy check-up (see Appendix F for the recruitment flyer). Women attended a check-up every 2 months, once a month, or fortnightly, depending on the stage of their pregnancy. Women who were eligible for inclusion in this study were anticipating giving birth normally at the study site between April and December 2016. They did not, at the time of recruitment, have any health problems.

I introduced myself to the participants and let them know that I was not a member of the maternity centre staff. The aim of this was to reduce the likelihood of potential participants feeling coerced to participate (see Appendix F). If the pregnant women were interested in participating in this study, they were given the information letter (see Appendix G) and informed consent form (see Appendix J). I read the informed consent form out loud to make sure that we read each statement at the same pace. In Indonesia, people have tended to sign without reading the statement when asked to provide informed consent. As Business View (2015) said about Indonesian people, ““Yes” can simply mean, “yes, I hear you”, not, “yes, I agree”; so ensure your message has been fully understood”. I explained the aims and design of the study, and that participation in the study was voluntary, and that the participant was free to withdraw at any time with or without reason and without penalty. I also explained to the participant that the interview would be confidential and recorded and the data would be used for research purposes only. If the woman, or her support person, was willing to participate, s/he signed the informed consent. Participants could keep the information letter and a copy of the consent form for their future reference and records.

I informed the participant when the recorder was started and stopped to make sure that they knew when the conversation was being recorded and recording had ended in order to provide a sense of security and comfort.

Once participants consented to participate in this study, I then arranged to recruit their support person to give them an information letter (see Appendix H) and informed consent form (see Appendix J). By agreeing to participate, the support person agreed to accompany the woman during childbirth. I met the support person at the maternity centre

at least 3 times to listen to his/her story about the experience accompanying the woman during her pregnancy, childbirth, and after birth. If the support person did not agree to participate, the participant woman was thanked and excluded from the study.

In the days after a participant woman gave birth, I approached the midwife who cared for her to invite her to participate also. Eligible midwives were given an information letter (see Appendix I) and an informed consent form (see Appendix J). Finally, all the participating midwives were assured of the right to withdraw from this study at anytime without reason and without penalty.

3.7.2 Interviews before labour and childbirth

I visited the maternity centre prior to each woman's expected birth date to build rapport with the woman and the support person. This was two weeks prior to the birth date. This opportunity was used to interview the woman's expectations of their birth experience. In addition, I also interviewed the support person about their experience during the woman's pregnancy period.

At the beginning of each interview, I affirmed the participants' willingness to be interviewed about the topic. As only the participant and I were in the room, no one could hear or disturb the interview process. The stories that were obtained were recorded on an audio-recorder. I also restated to participants that the data collected would be kept confidential. The interview guidelines are provided in Appendix K.

3.7.3 Interviews about support in labour and childbirth

One or two days after each woman gave birth, I visited her at the maternity centre to interview her about her experience of being supported during labour and childbirth. I also interviewed the support person about their experience of supporting the woman during labour and childbirth.

In addition, one or two days after the woman gave birth, I interviewed the midwife who helped the woman give birth about her experience helping the woman while she was accompanied by the support person during labour and childbirth. In some unplanned caesarean cases, I also interviewed the doctor who did the caesarean about the doctor's experience helping the woman while she was accompanied by the support person during labour, before enter the surgery room. The interview guidelines are provided in Appendix K.

3.7.4 Interviews weeks after labour and childbirth

Six weeks after the woman gave birth, I visited the maternity centre to interview the woman again about her birth experience. Once again, I also interviewed the support person about their experience with respect to the woman giving birth. The interview guidelines are provided in Appendix K.

3.7.5 Transcription and translation

Following each interview, I transcribed the stories and identified any areas that required further attention in future interviews. I transcribed the interviews in *Bahasa Indonesia*, the original interview language, to retain the original sense. After the themes

were identified, I translated these into English for checking with supervisors and reporting in this thesis.

3.8 Data analysis

After collecting the data, I restoried the stories of the participants using the three-dimensional space narrative structure proposed by Clandinin and Connelly (2000) to identify the key elements of the story (Creswell, 2015). I then reorganized the story based on the codes applied, as per the above descriptions, into chronological order.

After restorying, I coded the story for themes. My identification of themes was an inductive process, from detailed data to more general themes. A sample of the data analysis process is presented in Table 2.

Table 2

An Example of the Data Analysis Process

| Transcription of audiotape (raw data) | My retranscription | My restorying |
|--|---|---|
| “Just being ready ... I want something ... ask something ... need something ... he should be there anyway ..” (laugh). | (At the time of labour (s), I (c) expect (a) that my husband (c) is) just being ready (a) ... (if) I (c) want (a) something ... ask (a) something ... need (a) something ... he (c) should be (a) there anyway ... | - At the time of labour, I expect that my husband is just being ready. - If I want something ... - If I ask something ... - If I need something ... - He should be there anyway ... |

3.9 Member checking

I conducted a member checking exercise to make sure there were no misunderstandings in the data (Cohen & Crabtree, 2006; Creswell, 2015; Streubert & Carpenter, 2011). I worked collaboratively with the participants throughout the study and asked for their validation of the final report as recommended by (Creswell, 2015). I also met the women, support persons, and midwives to conduct a member checking exercise in order to gain the same understanding with them (see Figure 27 to 29).



Figure 27. Member checking with the women.



Figure 28. Member checking with the support persons.



Figure 29. Member checking with the midwives.

3.10 Reflexivity

This thesis discloses my beliefs, values, and the emotions I felt during the study so that the reader is aware of how these, along with my prior assumptions about giving birth and the value of companionship in the experience, might have influenced the study.

In the course of this study, I found that there were many times when I had to wait for unpredictably long times to meet with pregnant women or midwives (see Appendix L). While I tried to be patient, I sometimes felt confused by these experiences. I tried reflecting on them as life lessons (i.e., I should be more patient). Having tried to do my best and accepting that many factors were beyond my control, I tried to accept and enjoy the experience and seek the meaning behind that experience. In these reflections, I felt the truth and wisdom of Javanese values and philosophy relating to *nrimo* and *pasrah* that urge us to be more patient and full of faith in this life.

When interacting with the midwives, doctors, and health care staff, I felt I was an accepted part of the St. Vincentius a Paulo Catholic Hospital community. I appreciated being invited as a volunteer presenter to this community and that my informal conversations with the midwives and health care staff about their problems had equipped me to give a presentation about “Stress in Children” (see Figures 30 to 32) to that community. Having received kindness from others in my life, particularly from my study participants, I was keen to repay that kindness.



Figure 30. Presenting my session.



Figure 31. The participants at the presentation session.



Figure 32. I and the steering committee for the presentation session.

My presentation was well-attended and appreciated. The steering committee was surprised to find the presentation room was full, even beyond its capacity (Figure 31), as that had never happened before. The presentation may have been popular because it addressed a topic the audience saw as relevant and problematic. I was pleased that my presentation seemed to be relevant and useful to the community and their families. Hospital staff who attended my presentation often greeted me and chatted to me when they saw me at the hospital. I felt even more accepted as a member of the St. Vincentius a Paulo Catholic Hospital family after this event: this exercise served to strengthen my engagement with the organisation, and by extension had a positive influence on the staff members' engagement with the study.

In general, I am grateful for my experiences during this study. I learned many good lessons from this study, particularly, unconditional love, humility, patience, and

also fortitude. These help me to continue growing in my life and contribute more to others.

3.11 Summary

This study used narrative inquiry to address its research question: How do childbearing women birthing in (a typical) Indonesian maternity centre experience the presence of a known, trusted support person? The study recruited healthy pregnant women to be interviewed before, during, and after birth at the maternity center in Surabaya. Other interviews were arranged to collect the perceptions of the women's support person and midwife in order to gain a more complete understanding of the women's birth experience.

The data gathered in these interviews were analyzed using the two approaches outlined by Polkinghorne (1995): analysis of narrative and narrative analysis. The reason for using both approaches was to understand more about the participants' experience in order to provide more contributions to knowledge and community in this area.

This chapter also outlined the values and experiences influencing me as a researcher. The next chapter reports the data and provides an understanding of the participants' experience of and feelings about the phenomenon of interest.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter reports the findings of this study. After describing the study's participants and their demographics, it provides a short profile of each of the participants. It recounts the story and reports the emergent themes relating to the expectations and experiences of having and giving support in labour and childbirth. The stories and themes of the women, support persons, and midwives are reported in chronological order: before, during, and after labour and childbirth.

4.2 Description of the Participants

This study's participants comprised pregnant women and their designated support persons and midwives. Each data set was planned to consist of a pregnant woman (interviewed 3 times), a support person (interviewed 3 times), and a midwife (interviewed once). Some of the participating women and support persons were, however, unable to attend all of the scheduled interviews. As Table 3 shows, only 21 women and their designated support persons participated in all three interview stages and this is less than the number of participating midwives who only needed to attend a single interview.

Table 3

The Number of Interviews during March – December 2016

| Interview | Women | Support persons | Midwives | Total |
|------------------------------|-------|-----------------|----------|-------|
| Before labour and childbirth | 37 | 31 | - | 68 |
| During labour and childbirth | 24 | 22 | 30 | 76 |
| After labour and childbirth | 21 | 21 | - | 42 |
| Total | 82 | 74 | 30 | 186 |

Some women and their support persons did not complete all interviews because the women:

- gave birth at a public health centre rather than at the St. Vincentius a Paulo maternity centre (as noted in Chapter 3, some women opt for this no-cost option when check-ups at the maternity centre show they can expect an uncomplicated vaginal birth);
- failed to return for check-ups at the maternity centre;
- gave birth so much earlier than predicted that the researcher had no opportunity to conduct the planned interviews.

This study analysed data from the 21 complete data sets for women and support persons and their midwives to develop its initial representative categories, and the remainder of the data (including data from midwives who attended women not completing the full set of three interviews) were used to ‘thicken’ these categories. Of those 21 women, 15 had normal vaginal births and six had caesarean sections as the result

of decisions taken by their doctors after the women had been in labour with their support person present for some time.

4.3 Demography of the Participants

A very brief description of the participants is presented in Tables 4 to 9.

Table 4

Age of Participants

| Age (year) | Women | | | | | | Spouse | | | | | |
|-----------------------|--------------|----------|----------|----------|-----------|--------------|---------------|----------|----------|----------|-----------|--------------|
| | N | | C | | T | | N | | C | | T | |
| | F | % | F | % | F | % | F | % | F | % | F | % |
| 16-20 | - | - | 1 | 16.67 | 1 | 4.76 | - | - | 1 | 16.67 | 1 | 4.76 |
| 21-25 | 4 | 26.67 | 1 | 16.67 | 5 | 23.81 | 3 | 20 | - | - | 3 | 14.29 |
| 26-30 | 5 | 33.33 | 1 | 16.67 | 6 | 28.57 | 3 | 20 | 1 | 16.67 | 4 | 19.05 |
| 31-35 | 5 | 33.33 | 3 | 50 | 8 | 38.10 | 7 | 46.67 | 4 | 66.67 | 11 | 52.38 |
| 36-40 | 1 | 6.67 | - | - | 1 | 4.76 | 2 | 13.33 | - | - | 2 | 9.52 |
| Total | 15 | 100 | 6 | 100 | 21 | 100 | 15 | 100 | 6 | 100 | 21 | 100 |

Note:

N = Normal.

C = Caesarean.

T = Total.

F = Frequency.

Table 4 presents the age distribution of participants. The vast majority of pregnant women in the sample were aged below 35 years (95.24% of all women, 93.33% with normal births, and 100% with caesarean births). The majority of spouses also were aged

below 35 years (90.48% of the spouses of all women, 86.67% of spouses of women with normal birth, and 100% of spouses of women with caesarean birth).

Table 5

Education (Highest Qualification Obtained) of Participants

| Education | Women | | | | | | Spouse | | | | | |
|--------------------|-------|-------|---|-----|-----------|--------------|--------|-------|---|-------|-----------|--------------|
| | N | | C | | T | | N | | C | | T | |
| | F | % | F | % | F | % | F | % | F | % | F | % |
| Elementary school | 1 | 6.67 | - | - | 1 | 4.76 | 1 | 6.67 | 1 | 16.67 | 2 | 9.52 |
| Junior high school | - | - | - | - | - | - | - | - | - | - | - | - |
| Senior high school | 7 | 46.67 | 3 | 50 | 10 | 47.62 | 6 | 40 | 3 | 50 | 9 | 42.86 |
| Diploma | 2 | 13.33 | - | - | 2 | 9.52 | 3 | 20 | - | - | 3 | 14.29 |
| Undergraduate | 5 | 33.33 | 3 | 50 | 8 | 38.10 | 5 | 33.33 | 2 | 33.33 | 7 | 33.33 |
| Total | 15 | 100 | 6 | 100 | 21 | 100 | 15 | 100 | 6 | 100 | 21 | 100 |

Note:

N = Normal.

C = Caesarean.

T = Total.

F = Frequency.

Table 5 presents the education distribution of participants. The minimum level of education of the vast majority of pregnant women in the sample was senior high school (95.24% of all women, 93.33% with normal childbirth, and 100% with caesarean birth). The minimum level of education of the majority of spouses was also senior high school

(90.48% of the spouses of all women, 93.33% of spouses of women with normal birth, and 83.33% of spouses of women with caesarean birth).

Table 6

Religions of Participants

| Religions | Women | | | | | | Spouse | | | | | |
|-------------------------|-------|-------|---|-------|-----------|--------------|--------|-------|---|-------|-----------|--------------|
| | N | | C | | T | | N | | C | | T | |
| | F | % | F | % | F | % | F | % | F | % | F | % |
| Islam | 13 | 86.67 | 4 | 66.67 | 17 | 80.95 | 13 | 86.67 | 4 | 66.67 | 17 | 80.95 |
| Roman Catholicism | 1 | 6.67 | - | - | 1 | 4.76 | 2 | 13.33 | - | - | 2 | 9.52 |
| Protestant Christianity | 1 | 6.67 | 2 | 33.33 | 3 | 14.29 | - | - | 2 | 33.33 | 2 | 9.52 |
| Total | 15 | 100 | 6 | 100 | 21 | 100 | 15 | 100 | 6 | 100 | 21 | 100 |

Note:

N = Normal.

C = Caesarean.

T = Total.

F = Frequency.

Table 6 presents the religion of participants. The majority of pregnant women in the sample were Muslim (80.95% of all women, 86.67% with normal childbirth, and 66.67% with caesarean birth). The majority of spouses in the sample were also Muslim (80.95% of the spouses of all women, 86.67% of spouses of women with normal birth, and 66.67% of spouses of women with caesarean birth).

Table 7

Working Status of Participants

| Working | Women | | | | | | Spouse | | | | | |
|----------------|--------------|----------|----------|----------|-----------|--------------|---------------|----------|----------|----------|-----------|------------|
| | N | | C | | T | | N | | C | | T | |
| | F | % | F | % | F | % | F | % | F | % | F | % |
| Working | 7 | 46.67 | 2 | 33.33 | 9 | 42.86 | 15 | 100 | 6 | 100 | 21 | 100 |
| Not working | 8 | 53.33 | 4 | 66.67 | 12 | 57.14 | - | - | - | - | - | - |
| Total | 15 | 100 | 6 | 100 | 21 | 100 | 15 | 100 | 6 | 100 | 21 | 100 |

N = Normal.

C = Caesarean.

T = Total.

F = Frequency.

The working status of participants is presented in Table 7. The majority of pregnant women in the sample were housewives (57.14% of all women, 53.33% with normal childbirth, and 66.67% with caesarean birth). All of the spouses of all women, both with normal and caesarean birth, were working (100% of the spouses of all women, with normal and caesarean birth).

Table 8

Number of Pregnancies Experienced by the Women

| Pregnancy | Women | | | | | |
|-----------------|-------|-------|---|-------|-----------|--------------|
| | N | | C | | T | |
| | F | % | F | % | F | % |
| 1 st | 8 | 53.33 | 3 | 50 | 11 | 52.38 |
| 2 nd | 5 | 33.33 | 1 | 16.67 | 6 | 28.57 |
| 3 rd | - | - | 1 | 16.67 | 1 | 4.76 |
| 4 th | 2 | 13.33 | 1 | 16.67 | 3 | 14.29 |
| Total | 15 | 100 | 6 | 100 | 21 | 100 |

Note:

N = Normal.

C = Caesarean.

T = Total.

F = Frequency.

The number of pregnancies experienced by the pregnant women is presented in Table 7. The majority of pregnant women in the sample were primiparous (52.38% of all women, 53.33% with normal childbirth, and 50% with caesarean birth). The minority of pregnant women in the sample were multiparous (47.62% of all women, 46.67% with normal childbirth, and 50% with caesarean birth).

Table 9

Relationship of the Support Person to the Women

| Support person | Women | | | | | |
|-------------------|-------|-----|---|-----|-----------|--------------|
| | N | | C | | T | |
| | F | % | F | % | F | % |
| Husband | 12 | 80 | 6 | 100 | 18 | 85.71 |
| Mother | 3 | 20 | - | - | 3 | 14.29 |
| Total | 15 | 100 | 6 | 100 | 21 | 100 |

N = Normal.

C = Caesarean.

T = Total.

F = Frequency.

Table 8 shows the relationship of the support person to the pregnant women. The vast majority of pregnant women in the sample were supported by the husband (85.71% of all women, 80% with normal childbirth, and 100% with caesarean birth). The minority of pregnant women in the sample was supported by the mother (14.29% of all women, 20% of women with normal birth, and 0% of women with caesarean birth).

4.4 Short Profile of the Participants

In order to provide a comprehensive view of the pregnant women participants, the following section briefly describes the 21 woman/support person combinations with complete data sets used in the initial development of the emergent representative categories.

4.4.1 Short profile of the normal childbirth participants

W1/31/1st (Woman 1, 31 years of age, 1st pregnancy). She lived with her husband/33 (33 years of age) only, although sometimes her mother visited her and her husband. She was working in marketing and planned the pregnancy. She chose her husband to be her support person during labour. Her husband, who was working at home, was extremely supportive.

W7/39/4th lived with her husband/39. Her three previous pregnancies had resulted in two children (male/18 and female/11), who were still living at home, and a son who had died in the 8 month of her pregnancy. Her husband, who was working as a driver, was looking forward to another baby and he and their family and friends provided great support to this woman throughout her pregnancy. She chose her husband to be her support person during labour.

W10/30/2nd was the only child in her family. She lived with her husband/34, son/4, father, mother, and grandfather. As her husband was unwilling to accompany her during labour, she chose to have her mother as support person because her mother had experienced childbirth. Her mother understood and fully supported her. All members of the family supported her pregnancy.

W12/29/1st lived with her husband/35. She had married on 17 May 2015, 12 months before she gave birth. Her husband planned this pregnancy because he was 35 years old and expected to have a baby soon. She expected to be accompanied by her husband during labour. Her husband, who was a health staff member at the hospital, supported her very much.

W13/23/1st. She lived with her husband/30 in Bandung, West Java. As she did not have any family in Bandung, her husband advised her to have her pregnancy check-ups in Surabaya, where many members of her family were available for support. She, therefore, returned to Surabaya 3 months into her pregnancy and stayed in her mother's house.

While she expected to have her husband as her support person during labour and childbirth, she had worried that his working in Bandung might prevent him from being present. He was however able to serve as her support person during labour and childbirth,

W16/31/2nd lived with her husband/34 and her son/8. While her husband wanted to have three children, she had planned to have only two children. She chose to have her husband as a support person.

W18/25/1st was a member of the health staff at the hospital and lived with her husband/26. She planned her pregnancy soon after her marriage in October 2014. She managed her pregnancy in accordance with many traditional beliefs and practices, such as:

- not bathing at night in order to avoid a build up of too much amniotic fluid.
- not eating spicy food in order to prevent her child's eyes becoming dirty.

This woman also experienced many “*ngidam*” (the Indonesian term for when a pregnant woman has cravings) during her pregnancy. Her husband was able to fulfil her *ngidam* for grilled fish. At one point, her husband (perhaps from empathy) experienced a similar craving) for avocado even though avocados were not in season at that time. She and her husband looked around the village and then went to many markets but were unable to satisfy her husband's craving for avocado. She chose her husband to be her support person during labour.

W19/22/1st was pregnant soon after marriage. After her husband/23 had a traffic accident and was cared for in a clinic that was close to his mother's house in Sidoarjo, the pregnant wife moved into her own mother's house closer to the maternity centre. She expected to have her husband as her support person, but her husband was unwilling to take on this role. Her own mother was likewise unwilling to take on this role and tried to persuade her not to have a support person during labour. This women's husband did eventually agree to serve as her support person

W20/21/1st. She lived with her husband/24, mother, father, brother, and nephew in her parents' house. As her husband could not provide financial support for his family, her parents offered to house them so that they could save money. She chose her husband to be her support person during labour.

W26/29/1st. She lived with her husband/25. She was advised by her mother to give birth in her home village in Nganjuk so that it would be easier to find support from family members, particularly her mother. By contrast, her husband's family advised her to stay in Kediri to have support from her husband's family. She and her husband, therefore, decided she would give birth in Surabaya to avoid jealousy between the two extended families. She chose her husband to be her support person during labour.

W27/27/1st was a member of the health staff at the hospital and lived with her husband/31 in a house close to her parent's house. Her mother supported her during the pregnancy by visiting her and cooking for her every day. This woman chose to have her mother as her support person because her mother had experienced giving birth.

W33/33/2nd lived with her husband and son/4. Her pregnancy was planned. She wanted her husband to be her support person so that he could learn about the birth

process. Her husband was, however, unwilling to take on this role, but agreed to do so after learning that he was permitted to close his eyes while holding his wife's hand during labour.

W40/28/2nd lived with her husband/28 and daughter/1.5 in Denpasar. Her pregnancy came as a surprise as she was still breastfeeding her daughter. To safeguard her unborn baby against nutritional deficiencies she weaned her daughter. As she had no family members in Denpasar to support her when her husband was working during the day, three months into her pregnancy she moved to her parents' house in Surabaya to have their support. She chose to have her husband act as her support person during labour so that he would learn how hard it is to give birth and have more empathy for her.

W42/34/4th was the only child in her family and had experienced loneliness as she had been the only child. She lived with her husband/34, 3 children (female/11; female/5; male/2.5), and her parents, who helped her to care for her children while she was working in marketing. While she welcomed her pregnancy, her mother suggested she stop having children as she already had three children. Her husband also suggested they have only three children as all of them suffered from allergies. Although both her mother and husband were concerned about financial issues related to raising children, they supported her during her pregnancy. She chose her husband to be her support person during labour as he performed this role during the birth of their last child.

W47/33/2nd lived with her husband/35, her son/7, her parents, and her sister. She planned to have 3 children and had tried to become pregnant for two years. She had been pleased to learn she was pregnant and all her family members and her parents in law

supported her pregnancy. She chose to have her husband as her support person during labour.

4.4.2 Short profile of the caesarean participants

W2/18/1st lived with her husband/20. She had become pregnant before their marriage. As women who fall pregnant outside of marriage are shunned in Indonesia for violating social norms, she had discontinued her studies at the senior high school because she did not want other people to know that she was pregnant. She had tried many times to abort her unborn baby by jumping and eating a lot of pineapples. She later gained support from her parents, parents-in-law, and the pastor of her church. During her pregnancy, she was quarantined at the church, accompanied and guided by the pastor and his wife and slowly over time came to enjoy her pregnancy. She chose to have her husband as her support person during labour. As she was found to have a venereal disease during labour, her doctor arranged for her to have a caesarean birth to safeguard the baby.

W24/35/1st lived with her husband/33. She had waited to fall pregnant since getting married six years ago. She chose to have her husband as her support person during labour in order that the husband could learn about the birthing process. In view of her difficulties in falling pregnant and her age, the doctor arranged for her to have a caesarean section to reduce risks for the baby. As her routine check-up had indicated no grounds for a caesarean birth, she questioned the doctor's decision but later she accepted the need for a caesarean birth to guarantee a safe birth for her baby.

W30/35/4th was a staff member of the hospital working in administration. She lived with her husband/34 and son/6.5. She was pleased to learn she was pregnant as

although she had planned to delay pregnancy for a further six months, her husband and son had wanted her to be pregnant more quickly. After her unsuccessful second and third pregnancies, she had to undergo cures. She chose her husband as her support person during labour. The doctor arranged a caesarean birth because the baby was overdue and the woman's first child had been a caesarean birth.

W41/27/2nd lived with her husband/32 and her baby (male/1.5). She did not plan this pregnancy. Because of that, at the beginning of her pregnancy she was not aware that she was pregnant. Her pregnancy came as a surprise as she was still breastfeeding her daughter. To safeguard her unborn baby against nutritional deficiencies she weaned her son. At the beginning of weaning, her son became stressed. He cried hysterically when he saw her. She felt grateful that she could stay with her parents. Her parents helped her to separate her from her son. In fact, she had planned to find a job again, but this plan was cancelled. She chose her husband to be her support person during labour. When her contractions became as frequent as every four minutes and the baby had not descended into the birth canal, the doctor arranged a caesarean birth.

W/43/24/1st lived with her husband/30 and had only been married for a short time. She did not plan her pregnancy and while happy to be pregnant, regretted having so little time to enjoy being married prior to her pregnancy. Her mother suggested she should fall pregnant because she was 6 years younger than her husband. This woman chose to have her husband as her support person during labour, because her husband was more patient and less talkative than her mother.

W/45/34/3rd lived with her husband/35 and daughter/10. Removal of her IUD (Intra Uterine Device) during her second pregnancy had resulted in the abortion of a male

foetus. Her husband seemed busy with “his own world” while she expected more concern from her husband. She chose her husband as her support person so that he would have more empathy for her. Because she had swollen feet and high blood pressure, she was advised to have a caesarean birth to avoid further problems. She could not accept this decision even after labour.

4.4.3 Short profile of the midwives/doctors

M1, M47/33 (Midwife of woman 1 and 47, 33 years of age). She enjoyed working as a midwife at this maternity centre. She tried to understand and provided good service to the pregnant women, particularly a new expectant mother.

M7/24. She was a junior midwife. Because of that, she was supervised by the senior midwife when helping the woman giving birth. It made her feel more nervous particularly when she was evaluated in front of the pregnant woman. However, she was satisfied when she could help the women giving birth well.

M10/31. She found many types of women and families when she helped the women giving birth. She learned how the women disclosed themselves during labour, without “mask”. She learned about life as her job as a midwife.

M12/37. She was reminded by her giving birth experience when helping the women giving birth. By being reminded her experience, she could understand the women better in order to help them giving birth.

M13/34. Based on her experience for years as a midwife, she could understand the women during labour and childbirth. She also shared her experience and supervised some junior midwives in order to help the women giving birth better.

M16/24. She enjoyed doing her job as a midwife at the maternity centre. She tried to do her job the best. She was satisfied when she found the process of giving birth was smooth.

M18/30. She enjoyed her job as a midwife at the maternity centre. She was glad that the husbands or mothers supported the women. This support helped the midwife, who was very busy because serving many women, doing her job.

M19, M26, M27, M40/37. She was a senior midwife who taught and supervised the nursing students who did fieldwork at the maternity centre. She enjoyed her job as a midwife and lecture at the maternity centre because she could share her knowledge and experience to the students so that the student could help the women giving birth well. She was also a steering committee of the St. Vincentius a Paulo nursing voluntary group at the hospital.

M20/30. She enjoyed her job as a midwife at the maternity centre. She enjoyed the friendly atmosphere there. This condition supported her doing her job helping the women giving birth better.

M33/34. She enjoyed working as a midwife at the maternity centre. However, sometimes she felt tired particularly when she found the woman needed a lot of support. She knew that she had to do her job well.

M42/35. She enjoyed her job as a midwife at the maternity centre. She was glad when she found the cooperative women and families. This condition supported her helping the women giving birth better.

D2/34 (Doctor of woman 2, 34 years of age). She enjoyed her job as a doctor at the maternity centre. She was glad when the caesarean process was smooth and found the baby and the woman were safe.

D24, D30, D41, D43, D45/55. He was a senior doctor and supervisor at the maternity centre. He tried to serve the women and supervise the midwives the best. He urged the midwives to persuade the women doing vaginal birth. He was also a steering committee of the St. Vincentius a Paulo nursing voluntary group at the hospital.

4.5 Women's Story

This study used narrative inquiry to provide the story of its participants, particularly the women who are the main focus of this study. Their stories summarise and extend the information provided in the previous section, and so assist in developing a generalised understanding of the experience of support during labour and childbirth. Through the women's story we meet the "self" of the women (Riessman, 2008).

4.5.1 The women's story before labour and childbirth (during pregnancy)

Most of the women had planned and expected their pregnancy. Once the women's period was two weeks overdue, the women informed their husbands and mothers, who then asked the women to get a pregnancy testing kit from a pharmacy and do a pregnancy test. Most bought a kit and did their pregnancy test at home in the morning. The first time the women knew for certain that they were pregnant was after their pregnancy urine test and most were pleased when the test result indicated they were pregnant. Some were surprised that they had become pregnant while they were still breastfeeding a baby.

The women were pleased with their husbands' response. Typically, the husband was so delighted to learn of his wife's pregnancy that he immediately kissed his wife's foreheads [kissing on the lips remains an unusual practice in Indonesia], and the husband and wife then expressed their gratitude to God by *sujud syukur* (Indonesian term expressing prostration of gratitude to God). Most of the husbands planned to accompany the women when they visited the doctor to have the pregnancy confirmed. A few husbands suggested their wives relocate in order to have ready access to support from her extended family during the pregnancy.

Both the women and their husbands were happy when their doctor confirmed the pregnancy test result. Once the pregnancy was confirmed, the husbands took care to support their wives. Husbands and wives shared the news of the pregnancy with their parents, parents-in-law, siblings, other family members, friends, and colleagues, who were all pleased to hear the news and eager to support the pregnant women. To ensure their foetus would be adequately nourished, some women chose to wean a baby they had been breastfeeding.

Due to their husband's work commitments, some housewives had been living with their husbands outside Surabaya in places where they lacked families or friends who could assist with tasks such as cooking and childcare while their husbands were working. To avoid feeling isolated and lonely at home, and to gain ready access to support from their families, they opted to return to Surabaya. Moving back to their hometown of Surabaya meant their mothers could accompany them to see the midwives at the maternity centre and help them to take care for their other children or take on tasks such as cooking so the pregnant woman could rest.

During the first months of pregnancy, some women suffered physical disturbances such as morning sickness, vomiting in response to particular odours, or an inability to eat their normal daily meals of rice. These disturbances typically diminished during the middle or late stages of pregnancy.

The husbands' concern about safeguarding the health of their wives and unborn babies led them to remind their wives to eat nourishing food and have regular check-ups at the maternity centre. Husbands gave these reminders in-person at home or by phone or text message from their workplaces. If their wives experienced *ngidam* for specific food, the husband tried to satisfy those cravings even when obtaining a particular food involved considerable travel or the food was required late at night well after the shops had shut. Women with cravings appreciated receiving this level of support from their husbands.

The women's mothers also acted to ensure the pregnant women ate nourishing foods. After learning that their daughters were pregnant, the mothers supported their pregnant daughters by cooking for them every day. Some mothers stayed with their pregnant daughters, others visited their pregnant daughters' houses daily to prepare highly nutritious meals for them. Some mothers also helped pregnant daughters by cleaning their households and caring for the children of pregnant daughters who felt tired and needed to take a rest.

When their husbands could not accompany the women to check-ups at the maternity centre, the mothers accompanied them. The mothers also reminded the women to pray more and avoid harbouring negative thoughts and to do other things to support their pregnancy and assist delivery of healthy babies. Some parents still believed in traditional beliefs and practices and advised the women to adopt practices such as

keeping scissors in their bag whenever they went out in order to prevent the unborn baby being stolen by the devil, not showering at night to avoid having too much amniotic fluid, refraining from eating chillis to prevent the babies from having dirty eyes. This advice from their mothers led the women to feel helped and supported.

The pregnant women also felt supported by colleagues in their workplaces, who insisted the women avoid heavy manual work, such as lifting boxes, as they had been accustomed to do prior to becoming pregnant. If women still attempted these tasks, their colleagues asked them to leave the box for them to carry. The women enjoyed receiving this widespread support.

The midwives also supported the women by providing regular check-ups at the maternity centre. In the interest of their own health and that of their unborn babies, the women were advised to eat nutritious food, get enough rest, and attend the pregnancy gymnastics at the maternity centre during the third trimester to strengthen their bodies and muscles for labour and childbirth. The midwives also reminded the women about the signs that signal the start of labour. This advice from their midwives led the women to feel helped and supported.

The women felt special and well-supported by many other people around them. People on the crowded streets showed respect by allowing the pregnant women to go first or reminding others to provide enough space so the women could go past. One individual announced to others on the street, “Excuse us... excuse us ... please step aside ... please step aside ... there is a pregnant woman wanting to pass ...”.

A Javanese traditional ceremony for the pregnant women named *Mitoni* or *Tingkeban* (see Appendix B1) was held to mark the seventh month of pregnancy. The

objective of the ceremony was to pray for the welfare of a woman and her unborn baby in order to have a smooth birth. Even people who did not perform the complete traditional ceremony still invited their families, friends, and neighbours to pray for the welfare of the pregnant woman and the unborn baby. Often at least 50 people came to the women's houses to celebrate their pregnancy, and would pray for the welfare of the woman and the unborn baby in order to have smooth birth. By being prayed for by parents, families, friends, and neighbours the women felt special and supported by others. Experiencing such support helped the women enjoy their pregnancy.

The women's most impressive and amazing experience during pregnancy was when they felt the movement of the unborn baby in their body for the first time. Some women who talked to and played with the unborn baby by touching their stomach felt that the baby responded by moving or changing their position. The women were amused by this responsive behaviour.

The husbands also felt impressed by the movement of the unborn baby inside the woman. The husbands knew that they could only experience this sensation because the wives were pregnant as touching the bellies of other pregnant women was not socially acceptable.

The women were pleased to be allowed to choose a support person to accompany them during labour and childbirth. All initially wanted their husbands as their designated support person. Most husbands agreed to take on this role even though some did not know what was involved or were even emotionally ill-prepared. The husbands generally tried to support the women as fully as they could, though some remained reluctant or

unwilling. In those cases, the women asked their mothers to be their designated support person.

The women expected that their support person would be someone they could talk to during labour. The women also expected that serving as a support person would teach their husbands about the childbirth process.

As the time of childbirth approached, the women became more anxious. They were uncertain about how it would happen, the kind of childbirth signs they would experience, whether this would be at night or day, at home or on the street, whether husbands who were working outside Surabaya would be on hand to act as support person, whether the birth would be simple or difficult, normal or caesarean. They just “*pasrah*” (Indonesian term meaning submit everything to the God’s will) and everything would be good.

The women expected that they would have normal births and not caesarean births. They expected that their labour and childbirth would be smooth and they and their baby would be safe and healthy. They expected to obey the midwives’ instructions because they trusted the midwives’ expertise and experience in helping the women give birth. The midwives at the maternity centre were well-known for taking good care of their patients. Some women had relatives such as grandmothers who had given birth there.

The women preferred to have check-ups and planned to give birth at St. Vincentius a Paulo maternity centre because of its reputation. They chose not to go to other public health centres that were closer to their home or were even free of charge for the women, as those centres had gained a reputation for poor patient care practices such

as shouting at labouring women. Other women such as a cousin who had given birth at the public health centre were the key sources of information about patient care practices.

While the women could not describe in advance how the support persons would act, they felt comforted that they would have their support persons present during labour and childbirth. Rather than being alone in an unfamiliar and unwelcoming childbirth room, they would be receiving support to help them feel comfortable and relaxed.

4.5.2 The women's story of labour and childbirth

When regular contractions or mucus or amniotic fluid appeared to signal the onset of labour, the women informed their support persons. If they did not know whether labour had begun, the women were advised to go to the maternity centre. Most of the women were accompanied by their support persons on the journey to the maternity centre.

On arrival at the maternity centre, the midwives informed the women about their condition in terms of the stage of labour and the expected duration of labour. Some women were advised to go home because labour had not begun and given more detailed information about the signs of labour that would signal a need to return to the maternity centre.

Women arriving at the maternity centre with two-centimetre dilation of their cervix were advised to go to the childbirth room for more detailed observation. While the midwives also advised the women to eat in order to have enough energy for childbirth, some women did not want to eat because of the pain they were experiencing. Their

support persons often managed to persuade women to eat or actually fed the women to ensure they had enough energy for childbirth.

During the typical eight hours of labour, the support persons understood, talked, prayed, consoled, stroked, held women's hand, massaged, fed, served, helped the women to find a comfortable position, guided the women to breathe as the midwives advised them, called the midwives, and discussed the women's condition with the midwives.

The support persons' presence during labour assisted the women to feel sufficiently comfortable, relaxed, secure, spirited, and strong that they did not scream. Women who had previously given birth without having a support person present were very positive about how having a support person present this time had impacted their experience of childbirth by giving them strength, helping them stay calm and feel secure. The women felt understood, accepted, and comfortable when their support persons expressed their empathy about the women's pain or stroked them.

Some women remembered advice that during labour they should ask forgiveness for their sins against their mother. Some women believed this and did this in order to have a smooth labour and childbirth.

Some women who could not stand the pain and screamed were advised by the midwives to save their energy and not scream. By contrast the support persons encouraged women to scream if their screaming would relieve their pain. When the support persons seemed to understand their pain, the women felt supported and free to express their feelings and be themselves.

Some husbands felt pity for the women who could not be strong after enduring pain for a very long time and asked the midwives if a caesarean birth could be arranged.

The midwives advised them this was not possible once the baby's head had reached the 'bottom of the uterus'. The midwives asked the husbands and women to be more patient as the baby was close to being born.

Some women reported that their husbands talked so much during labour that they used their own hands to close their husband's mouth. Other women felt annoyed when their husbands appeared not to understand their suffering, or explained the childbirth process in too much detail or made unfavourable comparisons with the husband's grandmother's, mother's, or sister's strength during labour and childbirth.

Some women managed their pain by squeezing or pinching their husband's hair, body or clothes, sometimes even tearing their clothes. Husbands who empathised with the women's pain helped them by remaining silent and letting the women do whatever they felt was necessary to manage their pain.

When childbirth was coming, the support persons strengthened the women by holding their hand, praying, saying supportive words: "You can ... you can ... a little bit more... the baby's head has been seen...". The women felt strengthened by the support persons during the childbirth process.

The husbands supported the women to obey the midwives' advice because they trusted it must be the best solution for the women and the babies and this applied even to caesarean births. The women felt safe when the husbands supported their having a caesarean birth. There was, however, one woman who refused to accept the necessity of the caesarean, but in the end she had no choice. That woman expected that her husband would stand up for her against the midwives in order to have a normal childbirth. She felt disappointed with her husband because he agreed with the midwives' advice about

having a caesarean. The midwives knew that the woman did not want a caesarean because she was worried about the cost that she might not be able to cover. However, the husband understood and told the midwives to do the best for the woman and the baby. He tried to find the necessary finances to cover the cost.

Women having caesarean births could only be supported by their husbands until the women were moved to the surgery room which the husbands were not permitted to enter. One woman felt anxious because her husband slept outside the transit room. However, she felt more relaxed when she listened to the religious music played from the midwife's mobile phone while the midwife was moving the woman to the surgery room. The husbands waited outside the surgery room until the women were moved to the recovery room.

After the baby was born, the support persons kissed the women's forehead and the husbands thanked the women. Some husbands held their tears after the childbirth process. Seeing the women struggle during labour and childbirth led some husbands to change their mind about having many children and to accept the number of children the women wanted or God gave. After the baby was given to them, some husbands whispered Islamic prayers into the baby's ear.

The midwives supported the women during labour and childbirth by guiding them gently and patiently and encouraging them with kind and supportive words. The midwives appreciated having the support persons' help to strengthen the women. After the baby was born, the midwives congratulated the women and announced the baby's gender.

Once the baby was cleaned, it was placed on its mother's breast to initiate breastfeeding. The women were impressed by their first contact with their newborn baby. They felt grateful that the baby they had carried for nine months in their womb had been born safely.

Family, friends, or colleagues who were waiting outside the childbirth room also felt glad when they knew that the birth was complete and mother and baby were doing well. They congratulated the women and their husbands after the women were moved to the wardroom. The women and the babies usually stayed at the maternity centre for two days.

The husbands or families shared the happy news by sending messages to their families, friends, or colleagues via their mobile phones. Most of their families, friends, or colleagues replied to the husband's or the women's families very quickly to congratulate the women and husbands and families or visited and gave presents to the women at the maternity centre.

The close relationships among people in the *kampungs* meant the neighbours usually saw the "bustle" when the women went to the maternity centre and later asked for news about the birth when the husbands and families returned home from the maternity centre. Neighbours also visited the women at the maternity centre to celebrate the birth and to congratulate and give presents to the women. The women were thus supported by their husbands, families, friends, colleagues, and neighbours.

4.5.3 The women's story after labour and childbirth

After staying at the maternity centre and returning home, the women were supported by their husbands and mothers. The mothers usually helped the women particularly until *Selapan*. *Selapan* is a Javanese traditional ceremony that celebrates 35 days of the baby (JogjaLand.net, 2014; Negoro, 1998b). In this ceremony the baby's hair and nails are cut. The objective of the *Selapan* ceremony is to pray for the welfare and safety of the baby in his/her life (JogjaLand.net, 2014).

The women were grateful that the husbands and mothers helped the women particularly during the first week the women returned home because the women needed time to recover their body from childbirth. Most women were helped by their mother during that period. Some of them were accompanied by their mother at night. When the baby cried at night, the mothers helped the women to find the best position to breastfeed the baby, changed the baby's diaper or rocked the baby when the baby might feel stifflingly hot. Most of the women lived in a natural air condition. The daily temperature in Surabaya, East Java, Indonesia is 25 – 33 degrees Celsius with a humidity level of 72% (timeanddate.com, 2018). It often makes people, including the women and the babies, feel stifflingly hot.

Some women returned to their home village outside Surabaya to have support from their parents, particularly their mothers, and families in taking care of the baby. The husbands visited the women and the baby on the weekend after working in Surabaya. The women stayed in the village at least for three months before returning to work in Surabaya. Some women left the baby with their parents in the village and visited them on the weekend after working in Surabaya. The women felt sad when they had to be

separated from the baby. However, they thought that it might be the best way for them at that moment because they had to work to earn money to support the family.

Some women, after about three months in their home village outside Surabaya being supported by their parents, particularly their mothers, returned to Surabaya with their baby for work. The women tried to find a trusted assistant to take care of the baby while they worked. They had been thinking about it since they were pregnant because it was not easy to find a trusted assistant. The women tried to find them among the families who needed work or asked their relatives or friends. The women felt grateful when they found a trusted assistant on time, around one or two weeks prior to the childbirth.

The women planned to be a good mother for their baby. The women asked advice and suggestions from their parents, particularly their mothers, about how to ensure the baby was healthy.

The women also took the baby for routine check-ups at the maternity centre. The midwives supported the women by providing information and advice. The women felt glad that they were still supported by their husbands, families, friends, colleagues, and midwives.

The women felt that their husbands seemed concerned with and loved the women more since the husbands accompanied them during labour and childbirth. The husbands were impressed with the experience of supporting the women during labour and childbirth. This experience changed their view of the women and increased the husbands' empathy towards the women. The husbands had a new enlightenment after seeing the women struggle during labour and childbirth. The husbands changed their plans to have many children and relied on the women's plans about the number of children the women

wanted. The husbands also submitted their plan to God because they believed that the children were given by God.

4.6 Summary of Themes

Themes were generated according the scheme outline in Figure 33.

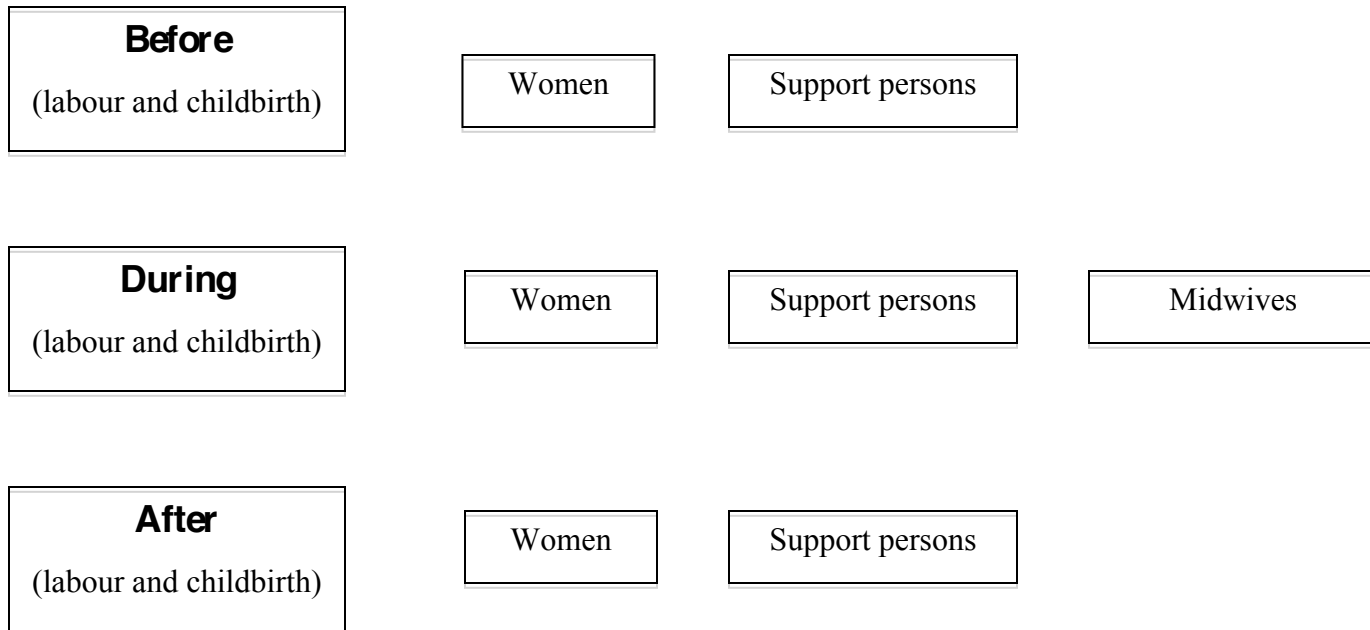
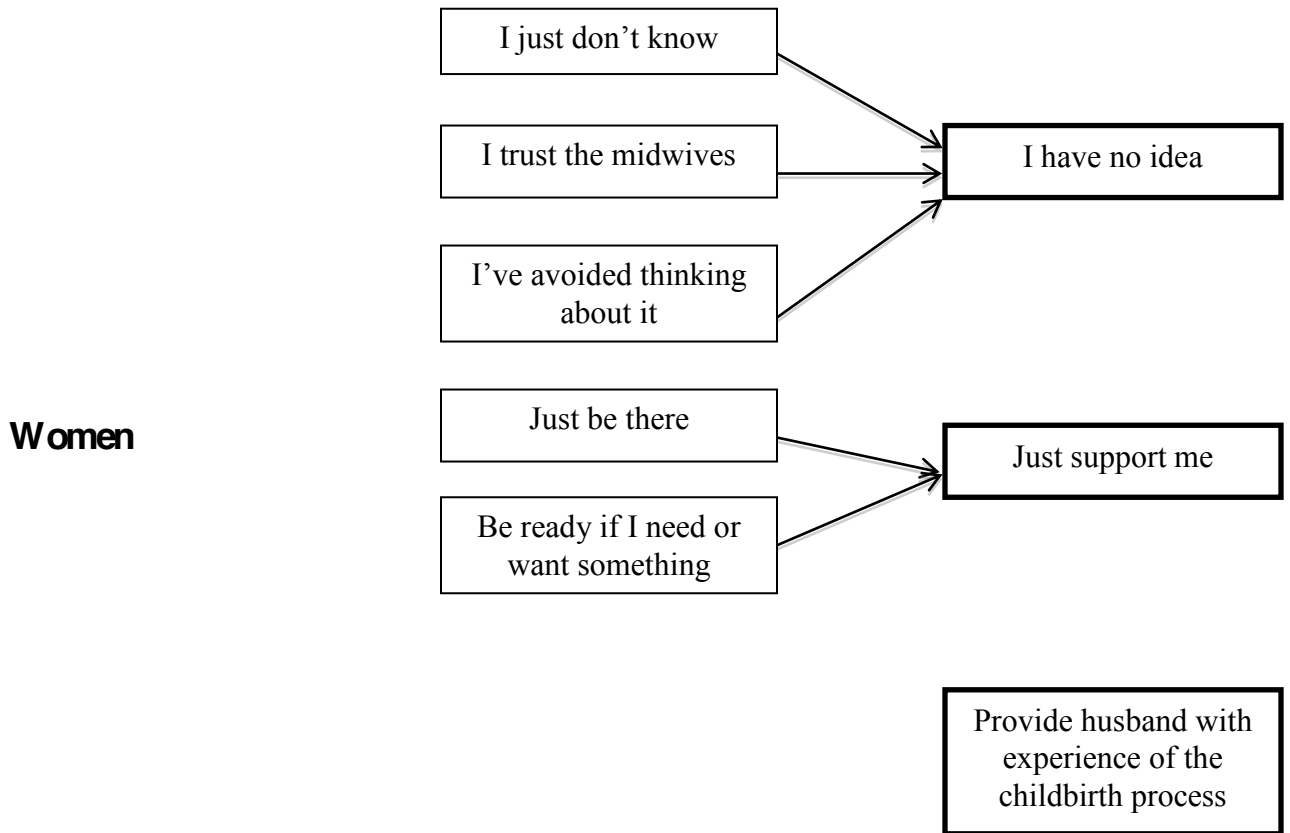


Figure 33. Source points for themes.


While the previous section describes the chronology of the women's story in general before labour and childbirth (during pregnancy), during labour and childbirth, and after labour and childbirth, this section concentrates on some moments that illustrate the women's, the support persons' and midwives' perspectives.

4.7 Research Question 1 – The Women’s Perspectives

4.7.1 Before – Women’s perceptions about support during labour and childbirth



Note:

 = Theme


 = Sub-theme

Figure 34. Themes and sub-themes of expectations of women about support during labour and childbirth (as revealed before labour and childbirth).

Figure 34 shows the themes and sub-themes of expectations of women about support during labour and childbirth (as revealed before labour and childbirth). The

women's expectations of support during labour consists of three themes, each of which has either two or three sub-themes.

4.7.1.1 Women's theme 1: I have no idea

About 71% of the women in this study could not describe the support they expected to receive during the labour and childbirth process. Instead they were prepared to submit to the instructions of the midwives during the labour and childbirth process. This was stated by eleven of the fifteen women who had a normal childbirth and four of the six women who had a caesarean delivery. Most of them gave very short responses (stating they "have no idea" without further explanation) when were asked their expectation about support during labour and childbirth.

When the women answered "I have no idea" without further explanation, I tried to probe for additional information by guiding them to imagine the labour and childbirth process. Coincidentally, the interview room provided by the maternity centre was a private examination room, and this may have helped the women to be able to "see" empirically how the labour and childbirth process would be. However, despite being guided to imagine their support person being with them intrapartum, most still could not describe their expectations in more detail. The possible reasons of this phenomenon are described in the next chapter.

The themes "I have no idea" consists of three themes: "I just don't know", "I trust the midwives", and "I've avoided thinking about it" are described below.

4.7.1.1.1 Women's theme 1, **sub-theme 1**: *I just don't know*

Some women claimed to have no expectations about the sort of support they wanted during labour and childbirth. They just could not conceptualise how it would be. The women's expectations under the sub-theme "I just don't know" are described below.

Woman 16: "I forget how the feeling ... because the first (labour)... feeling ... forget ... how it feel ... how the heartburn ... I always ask ... is the heartburn similar to menstruation? ... or similar to need to defecate? ... **I don't know**... just heartburn ... like that ... just confuse it ... worry about the kind of heartburn ... **No idea** about the giving birth process ... **I've had no idea** (what my husband will do)... **haven't thought about the process** ... just expect the baby can be born normally ... healthy ... and there will be no problem ...".

A similar sentiment was expressed by Woman 18: "I'm a delivery staff (in the hospital)... so when I passed the (childbirth) room I just imagine ... one day I will be there ... In the next few months I will be there ... **I have no idea** (about the childbirth process)...".

Woman 26: "**I've never thought** about what the childbirth process looks like ... (laugh) ... like what (laugh) ... just pass it ... Wish the (giving birth) process can still be normal ... and the bleeding is not too much ..."

Woman 27: "Like what (laugh) ... **never thought about it** (laugh) ... because it may be spontaneous ... that's why **I cannot imagine** ... I've known the childbirth room when I needed to go there because I'm a health staff here ... oh, this is the childbirth room .. it seemed scary (laugh) ... the apparatus, etc. ...".

Woman 33: "**I've never thought** about the process ...".

Woman 40: “**I don’t know** ... because it was said that each childbirth process is different ...”.

4.7.1.1.2 Women’s theme 1, sub-theme 2: I trust the midwives

Some women who had no idea about the birth process said that they just trusted the midwives. They seemingly had no expectations about the childbirth process but trusted the midwives would get them through it. The quotations of the women’s expectations under the sub-theme “I trust the midwives” are described below.

Woman 2: “I think more about after the childbirth ... not the childbirth process ... the pain ... **should surrender (to the midwives)** ... childbirth should be painful ... I think more for the future ... now there are two of us ... after this ... three of us ... how will we adapt to it ...”.

Woman 10: “I just imagine ... will it be night or day that I should go to the maternity centre ... when I feel anxious I try to imagine the process ... I just think ... **just trust (the midwives)** ... the midwives here are well known for always caring ... just pray ... expect all will be smooth ...”

Woman 18 who is a staff on the hospital: “When I passed the (childbirth) room just imagine ... one day I will be there ... In the next few months I will be there ... because **(the midwives are) friends ... should be good** ...”

Woman 20: “Have never given birth ... fear of painfulness ... **Pasrah** (Indonesian term to express *submit to God’s will totally* or *submit to anybody’s will totally or accept any condition that will happen totally* ... in this context it could be **trust the midwives totally**...) ... I don’t care ... painful ... don’t care ... what should I do? ... *Insya Allah*

(Islamic term to express *by God's will*) ... will be strength ... Yeah... hope the midwives will be good ... helpful... and ... like that (laugh) ...”

Woman 24: “About midwife ... never thought about it... **I trust** ... based on my sister's experience ... **the midwife is an expert** ...”.

Woman 43: “I don't understand like that ... just flows ... **trust the midwives** ... whatever they say ... however they treat me ... the most important thing is normal childbirth ... and if possible... it's not painful ...”

4.7.1.1.3 Women's theme 1, sub-theme 3: I've avoided thinking about it

The data in this sub-theme conveys women's tendency to keep thoughts of how the labour and birth would be out of their mind during pregnancy. Some women described their expectations in contradictory ways. The possible reasons for this phenomenon are described in Chapter 5. Their expectations under the sub-theme “I've avoided thinking about it” are described below.

Woman 13: “I don't want to think about it ...” (laugh while closing her face with her two hands)... worry if I'm giving birth ... he (my husband) is so long (to come) ... by plane ... but, he must wait, mustn't he? ... he cannot go home anytime ... but giving birth can be anytime ... if midnight ... there is no plane ... have to wait the next morning ... I worry if I cannot be accompanied ... while I want to be accompanied by him ...”.

Woman 19: “Never imagined ... never imagined ... **should be calm anyway** ... if scared ... all (muscles) will be contracted ... (the baby) cannot be born”.

Woman 30: “Never thought about childbirth ... don't want to imagine it (laugh).

Woman 43: “**Huh ... never thought about it (childbirth process)** until then ...”.

4.7.1.2 Women's theme 2: Just support me

The second theme related to women's expectations is "Just support me". This theme has two sub-themes: "Just be there" and "Be ready if I need or want something".

Some women recognized that they had an expectation that they just wanted to be supported during labour and childbirth. The women's expectations under the theme "Just support me" are described below.

Woman 6: "Hmmm ... **I've never thought about it** ... what, huh? (laugh) ... I imagine if my husband ... if I suffer pain ... or what ... **he supports me** ... he must have no voice ... he may just stroke me ... it's because my husband can't give much support ... but, it's OK ... that's my husband ..."

Woman 8: "I want my husband to accompany me ... **I don't know what he will do** ... maybe just massage me or something ... **just support me...**"

Woman 40: "**I've never thought** about it ... **just want to be accompanied** ... yeah ... **just want to be understood** about the extreme pain I am feeling (laugh) ... **I don't have any idea** ... because my husband is very flat (?)... he may just look at the process... The personality seems very quiet.... I may be more comfortable with my mother ... it may be because my mother has experienced birth ... my mother understands what it feels like ... so she understands ... even without instruction, I was massaged ... wiping my sweat ... usually like that ... I was asked what I want ... drinking tea or something ... if my mother ... it must be like that ... if my husband just for a while accompanies me, just keeps silent ... no response at all ... Because of that I prefer my mother over my husband to accompany me ... but now ... it must be my husband ... because my mother must take care of my (first) child ..."

Woman 45: “**My husband can make me relax** ... praying ... (I) can hold his hand ... if my husband is outside ... to whom should I scream?... my husband(’s personality) is like that ... **I don’t know what I expect** ... he may say ... pray, Mum ... only like that ...”

Woman 47: “**Only giving support** ... yeah ... please be strong, etc. He may massage ... stroking ... (my) husband should know ... how the pain while giving birth Previous labour I scream ... because I’m alone at that time ... nobody talk with me ... (if my husband accompany me) I may be stronger ... so there is someone accompany ... **there is someone who provides support**”

4.7.1.2.1 Women’s theme 2, sub-theme 1: Just be there

Some women’s only expectation of the support person was that they were ‘there’ by their side during labour and childbirth. The quotations from the women’s expectations narratives under the sub-theme “Just be there” are described below.

Woman 10: “My mother may have a chat with me ... (my) previous labour (experience), the midwives had a chat with me ... **always beside me** ...”

Woman 12: “About childbirth process ... eh ... actually I’ve never thought about whether it will be normal or caesarean ... because since early education ... it’s OK that we suggest normal ... like that ... but we will not know the last position ... how the baby will be ... or how big my birth canal ... big or small... the baby ... big or small.. many possibilities .. so .. of course ... imagine normal ... but ... just tend to prepare myself ... normal or caesarean... just being ready ... the most important is all will be healthy ... If I imagine it is normal ... only push ... **there is my husband beside me** ... I don’t know ...

he will be bitten (by me) ... or he will be scratched (by me) (laugh) ... or I may do anything (to him) ... that's what I imagine ... He may just be my handle ... just be a pole (laugh) ... never experience ... I don't know (laugh) ..."

Woman 18: "Yeah ... (my husband) provide support ... yeah... **beside (me)**... natural induction, isn't it (laugh) ... I've never imagined ... **my husband is just beside me** ...".

Woman 20: "**He must be beside me always** ... giving support ... providing prayer... you can (give birth to the baby)... for the sake of child ... if it's painful ... (I) should hold ..."

Woman 33: "The most important thing is **being accompanied by my husband** ... but my husband told me ... he will be scared if he sees blood ... he could faint ... I don't know ... he might be for real or just joking with me ... don't know..."

Woman 41: "My husband **just accompany me** ... because I don't like to be alone ... he just tell funny stories ... not at the first childbirth ... he asked some questions to me while I was suffering pain ... (I want) him just to tell funny stories, feed me ..."

Woman 42: "**Just being accompanied** ... Yeah ... at least more comfortable ... because have friend ... not alone... like that ... even though just keep silent ... sitting ... do nothing ... have friend ..."

4.7.1.2.2 Women's theme 2, sub-theme 2: Be ready if I need or want something

Some women expected that the support person would be alert to their needs and wants and would be ready to step in and provide it when required. The women's

expectations under the sub-theme “Be ready if I need or want something” are described below.

Woman 1: “**Just being ready ... if I want something ... ask something ...** need something ... he should be there anyway ..” (laugh).

Woman 13: “It was easier being accompanied by husband ... **could request anything...**”.

Woman 24: “Just (for the husband) to know the (childbirth) process ... if **I need something ... want something** ... should only be like that ... should be no more than that (laugh)....”.

Woman 40: “More comfortable with mother ... it may because mother has known ... mother has understood how the feeling looks like ... so she understands ... even without instruction, I was massaged ... my sweat was wiped... usually like that ... **I was asked what I wanted** ... drinking tea or something ... if my mother ... it must be like that ... if my husband just for a while accompany me, just keep silent ... no response at all ...”

Woman 42: “Yeah ... husband is beside me ... like that .. as usual ... yeah... what else? ... just never thought about it ... Yeah, just stroking ... do you want to be massaged? ... was instructed to drink ... like that ... previously like that ... but I don’t want ... please do not touch ... just leave me ... because it’s hurt... if I was massaged I feel uncomfortable ... do you want to be massaged? ... no, thanks... Yeah ... at least more comfortable ... because have friend ... not alone... like that ... even though just keep silent ... sitting ... do nothing ... have friend .. If (there is) no husband, the situation is different ... because didn’t know if it’s allowed ... just the third that is accompanied

...It's different when I was not accompanied ... when I felt pain, I was alone ... the midwives still busy at that time ... serve five women ... so I was left alone ... then I felt pain ... no midwives around me ... I have felt pain but the midwife hasn't come ... just confuse ... nobody ... nothing happen ... alone ... if there is husband ... I have a friend ... dad, it has been done ... what ... please call the nurse or midwife, dad ... why was it so long? ... Has it been ready? ... then husband called the midwife ... more secure ... more comfortable ... **there is someone helping me** ... dad, help me to take the drink ... slant ... there is someone helping me ... then was slanted ...”

4.7.1.3 Women's theme 3: Provide husband with experience of the childbirth process

The third theme of women's expectation about support during labour and childbirth is “Provide husband with experience of the childbirth process”. Some women wanted to be accompanied by their husband in order to let their husband know about the childbirth process. The women's expectations under the theme “Provide husband with experience of the childbirth process” are described below.

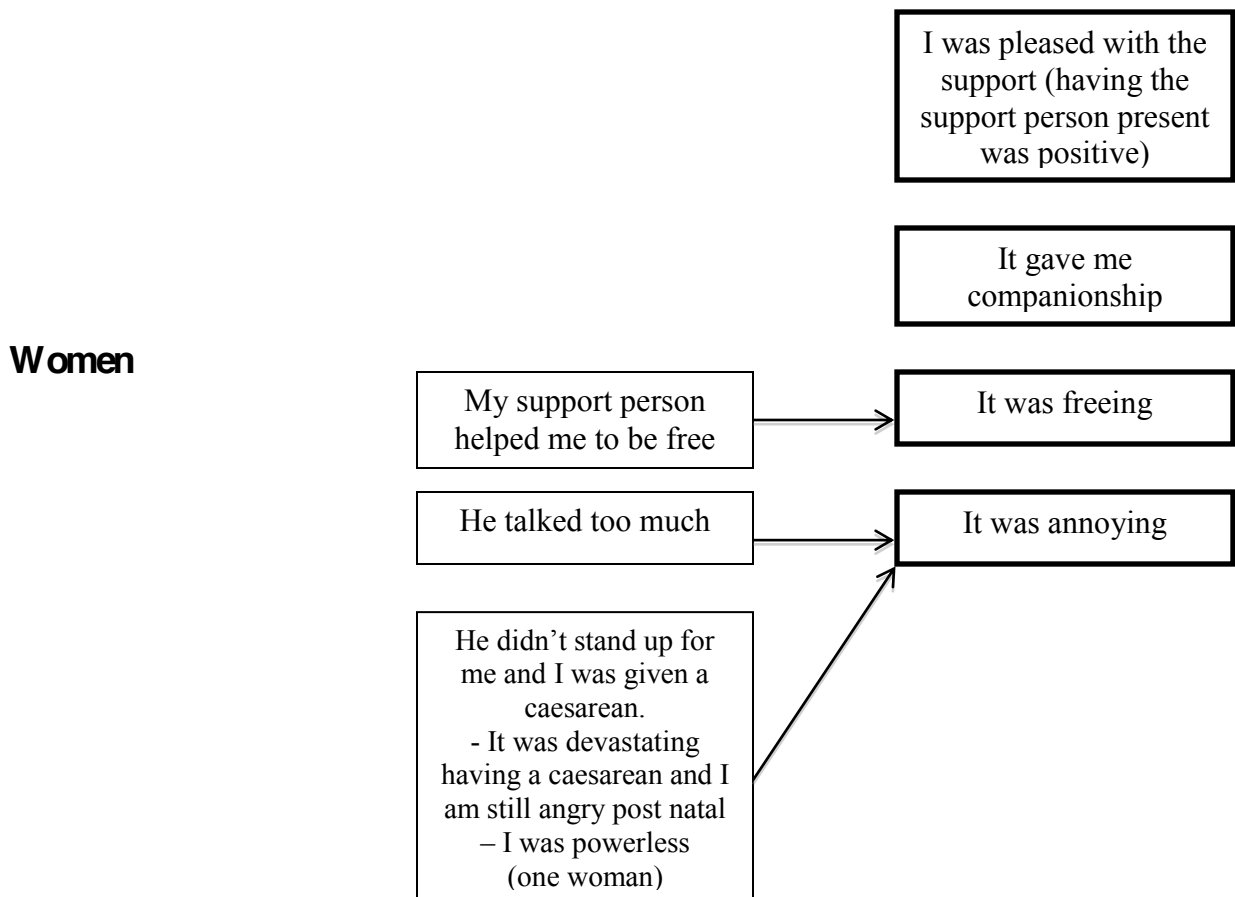
Woman 5: “Actually, I want my husband to accompany me so **he will know the childbirth process** ... the woman is giving birth ... like this ... painful ... so he is expected to love me more ... I sacrifice my life ... so that he will respect woman (me) more ... However, my husband cannot see blood ... he cannot see me suffer in pain ... ”

Woman 7: “What, huh? ... **just to let my husband know (about the childbirth)** ... hope all will be healthy and (the process) smooth ...”.

Woman 24: “**Just know the (childbirth) process (for the husband)** ... if I need something ... want something ... should only be like that ... should be no more than that

(laugh).... About midwife ... never imagined... I trust ... based on my sister's experience ... the midwife is expert ...”.

4.7.2 During - Women's perception about support during labour and childbirth



Note:

= Theme

= Sub-theme

Figure 35. Themes and sub-themes of perceptions of women about support during labour and childbirth (as reported 1-2 days after labour and childbirth).

Figure 35 shows the themes and sub-themes of perceptions of women about support during labour and childbirth (as reported 1-2 days after labour and childbirth).

All 21 women expected their husbands to accompany them during labour and childbirth. However, four of the husbands (10, 19, 27, 33) did not dare to accompany their wife during labour and childbirth but one of them (33) agreed to accompany his wife during labour and childbirth when he knew that he was allowed to not look at the woman during the process. Another husband (40) could not accompany his wife during labour and childbirth because he was still on the way to Surabaya from Denpasar at the time of the labour and childbirth. These women then asked their mothers to accompany them during labour and childbirth. One mother (19) did not dare to accompany her daughter during labour and childbirth and asked the woman to instead be independent. Finally, the husband accompanied her during labour and childbirth when he knew she expected a support person during the process.

When the time for childbirth arrived, six women ended up having a caesarean section. The operational standard at the hospital that supervises the maternity centre does not allow people to come into the surgery room, except the health staff. For this reason, six support persons accompanied the women before they went to the surgery room.

Four themes of women's experience regarding support during labour and childbirth were found. They were: I was pleased with the support (having the support person present was positive), It gave me companionship, It was freeing, It was annoying. Each theme is described below.

4.7.2.1 Women's theme 1: I was pleased with the support (having the support person present was positive)

All women, except one, felt pleased having their support person during labour. The women's experience under the theme "I was pleased with the support (having the support person present was positive)" are described below.

Woman 10: "It seemed ... there was a member of my family who accompanied me ... I felt ... how can I describe it (laugh) ... **glad** ... it's difficult to express (laugh)... I felt like ... **I was motivated** ... received attention ... **more comfortable** ...".

Woman 12: "My husband guided me comfortably ... **I felt comfortable** ... **I felt secure** ... comfortable ...".

Woman 20: "I get up a bit... **spirited** because my husband supported me...".

Woman 26 felt strong even though the husband asked her to not cry or complain because she trusted her husband. She felt secure because she knew that her husband, who was one of the medical staff, must know the stages involved in labour. Because of that she tried to follow her husband's advice.

Woman 26: "I was guided by my husband ... he reminded me ... if he wasn't there ... I might always scream ... I might be like my neighbour on the other bed (who was screaming) ... because my husband is one of the medical staff, **I felt more secure** and **relaxed** because my husband knew the stages ... I was helped by being accompanied by my husband ... **I was grateful** to be experiencing childbirth with my husband ..."

In general, 12 women who had normal childbirth and were accompanied by their husband felt comfortable during the process. They knew that the husband would support them endure this difficult time. The husband would do anything they needed or wanted.

Two women felt more comfortable being accompanied by their husband compared to their previous labour when they were not accompanied by their husband.

Woman 7: “**It’s more comfortable** now compared to my previous labour ... when I felt a little bit of pain ... I was massaged (by the husband) ... I didn’t ask... but it may be my husband thought that the pain would disappear (by being massaged)... I said pain ... heartburn ... he said ... yes ... it’s common like that ... please be patient ... hold just a moment ... **I felt glad** when my husband said that ... there was someone taking care (of me) ... so that he knew his role ... **I’ve never felt as strong as this (during labour and childbirth)** ... the previous ones were never like this ... I could feel the difference (feeling) ... (If I) felt pain ... there was someone to console (me) ...”.

Woman 47: “There was a different feeling compared to the first labour ... in the first one I was not accompanied ... **more comfortable with husband** ...”.

Furthermore, some women were also touched by their husband’s response.

Woman 16: “**(I felt) glad** ... more over when the baby was born ... (I) was kissed (on the forehead)...”.

Woman 18: “**Just be glad** ... I hold his hand ... after the baby was born I saw him cry ...”.

Other women preferred to be accompanied by their mother.

Woman 27: “**More comfortable with mother** ...”.

Woman 40: “**More comfortable with mother** ... she (mother) knows (the process) ...”.

Most women who had a caesarean childbirth felt comfortable when they were accompanied by their support person before entering the surgery room.

Woman 2: “The most supportive person was my husband ... because my mother did not dare to see ... *tidak tega* ... there was mother-in-law also ... but the feeling must be different ... at that time who can make me calm was my husband and of course myself ... because I could not expect anyone ... except myself ... my husband waited outside the surgery room ... because no one could come into surgery room except the medical staff ... actually I wanted to be accompanied by my husband in the surgery room... but the medical staff told my husband to wait outside the surgery room... I didn’t dare to ask the staff to allow my husband to come in ... so I just keep silent ... My husband was accompanying me at the maternity centre’s room before the surgery ... I felt... ehm... how to describe ... **felt calm**... there was a friend ... there was someone accompanying me so the anxiety was shared by both of us ... I’ve told him that I was scared ... he told me ... today (the caesarean) was OK ... it’s already prepared... I obeyed him... it’s OK that day ... ”.

Woman 47: “**I felt stronger** ... there is someone accompany ... there is someone who provides support ...”

4.7.2.2 Women’s theme 2: It gave me companionship

Many women were pleased that they had someone they knew, and who they knew cared about them, beside them during labour and childbirth. This is reflected in the theme “It gave me companionship”, and their quotations that contribute to it are described below.

Woman 1: “At least ... I know **there is somebody accompanying me during labour** ... even though he could not help physically ... but it did support me ... my

husband only prayed (laugh) ... whenever I wanted he was ready ... I need something ... want something .. my husband was ready ... whatever I asked ... he did for me ... massaged, asked for a drink, went to toilet, asked to fix the pillow position... many requests ... my foot has never been so itchy ... but the midwife told me that it was not allergy ... she asked me what type of medicine I consumed because if it was allergy usually after consuming medicine ... my husband scratched my foot for me ... even though he felt annoyed ... I've never had to scratch like this ... I didn't know ... just scratching (laugh) ... ”.

Woman 12: “When the time to give birth came I squeezed my husband (laugh) ... my husband told me ... please do not push ... this pushing was automatic (laugh) ... that's the (baby's) crown ... I was allowed to push when the contraction came ... when the baby was born ... even my husband was crying ... he might be touched ... **felt pity for me** who suffered pain ...”

Woman 13: “**It was easier being accompanied by husband** ... could request anything...”.

Woman 27 (crying): “I felt grateful there was a support person ... **a person who accompanied me** ...”

Some women wanted to be accompanied in order to show the husband what the childbirth process was like.

Woman 19: “I felt more comfortable ... **he now knows about the childbirth process**”.

Woman 33: “**(I) prefer to be accompanied by my husband** ... so he will understand (the process) ...”.

The women felt comfortable because there was someone there to talk with so they did not feel lonely.

Woman 10: “**I expected to be accompanied** ... so **there was someone who I can talk with** ... previously I talked with the midwife ... however, she was not always beside me ... it might be only 5 minutes ... after that she left me alone ...”.

Woman 40: “I was glad... **there was someone who I can talk with** ... there was someone who paid attention to me ... there was someone who was always ready beside me ...”.

Woman 47: “It was more comfortable with my husband beside me ... **there was someone I could talk with...**”.

In general, all women in this research felt comfortable when they had their support person during labour. This was because they knew that there was a person beside them to be ready and support them whenever they needed.

Three women felt comfortable and even more grateful having their mother as a support person during labour and childbirth. Two of them said that if they had their husband as a support person, it would not be helpful or it could have even made the situation worse.

Woman 10: “**I chose my mother as a support person** ... **my husband is scared** ... I asked my family ... who will accompany me ... it's allowed ... my husband said please do not (ask) me ... actually ... I also wanted my mother as a support person because we are women ... know (the process) ... if man ... it may only be in the urgent condition (if there is no woman) ...”

Woman 27: “**If I had my husband accompany me** ... when I said ... uhhh... pain ... he said ... I’ll call the midwife ... uhhhhh... no... I did not need ... I felt pain ... he was panicking ... **it would make me more confused** ...”.

Another woman (40) said that it there would be a significant difference between being accompanied by her mother and her husband.

Woman 40: “**If I had my husband during labour ... he wouldn’t know what to do** ... just keep silent ... because his personality was cool ...” Because her husband was a cool person, she actually wanted her husband to accompany her during labour in order to help him understand how painful the labour process is. By understanding the labour process, she expected that her husband could become more empathetic with her, and understand her feelings. She said, “At the beginning I expected my husband to be my support person during labour so that he would understand what I was feeling ... how much pain I felt ... because when I talked to him ... he was so cool ... just yes ... yes ... like that ...”. As a result, she felt more grateful having her mother present during her labour. Her mother, who had experience with birth, let her know what the process should be like that. By knowing that the process was normal and being understood, the woman felt calm and less anxious.

Woman 10: “In the beginning I choose my mother as a support person...**More comfortable with mother because she knows (the process)** ...”.

Another woman (27) felt supported when her mother told her, “It should be like that ... if you want to cry ... just cry ... if you want to scream ... just scream ... because the pain should be like that ...”.

Woman 24: “I was accompanied by my husband ... but my husband sometimes waited for me outside ...”.

Woman 30: “When I was told I was to have a caesarean birth... it’s OK if it’s the best way ... just trust God ... never thought of having a caesarean before ... I asked my husband to go home because it’s still very early ... just go to the maternity centre when the time was coming ... **My husband and my nephew had accompanied me** in the room at the maternity centre before I was taken to the surgery room. My surgery was planned for 8.00 am. However, the nurse picked me up earlier, before 8.00 am when my husband was in the rest room.”

Woman 41: “**My husband accompanied me** from the beginning... I felt glad ... He supported me ... helped me walk... like this ... but I wanted to sleep. The midwife told me, “Go, Mam.” ... OK ... I obeyed ... however when I felt pain ... was held by my husband ... it’s OK ... if I can walk by myself don’t hold me like a sick person ... when I stopped walking he touched my back ... it’s OK, please ... please don’t treat me like a sick person ... moreover in the public space like that ... shy ... I felt stronger because my husband accompanied me ...”

4.7.2.3 Women’s theme 3: It was freeing

4.7.2.3.1 Women’s theme 3, sub-theme 1: My support person helped me to be free

Women described how their support person encouraged them to be ‘free’ during labour and childbirth. The majority of support persons provided encouragement to women to behave as they wished even when it contradicted the midwives’ advice. One example was women being discouraged by midwives from screaming, supposedly to save

their energy for childbirth, however, the support persons supported the women to scream as long as it would help them. The women's experience under the theme "My support person helped me to be free" are described below.

Woman 27 felt supported when her mother told her, "It should be like that ... if you want to cry ... **just cry** ... if you want to scream ... **just scream** ... because the pain should be like that ..."

Woman 19 kept screaming even though the midwife asked her not to scream. The woman said that she tended to push when the pain during contraction started. However, the midwife asked her to not push because it was not the time to push. The woman was not able to do both, not push and not scream, at the same time. Because of that, the woman released her pain during contraction by screaming. She said that she could choose between pushing and screaming. She tried to not push and chose screaming as her coping strategy during that time.

Woman 19: "**After screaming I felt relieved** rather than holding in the feeling ... when the pain came, **I squeezed my husband's head and hair** ... the pain reached up to the top of my head ...".

Woman 13 said, "My husband told me ... if you want to scream ... **just scream** ... **just vomit** ... actually I felt guilty about the cleaning staff ... the midwives said, please do not scream because it takes a lot of energy ... but because my husband said, **it's OK ... OK Just scream ... just vomit** ... I felt ... like that I felt more calm, didn't dare ... **free**... but because there was support from my husband ... it's OK to scream ... I just keep screaming It was a different feeling to what I imagined if my husband was not beside me..."

4.7.2.4 Women's theme 4: It was annoying

Some women also found that sometimes the support person did not act as they expected. This is reflected in the theme “It was annoying”, which has two sub-themes: “He talked too much” and “he didn’t stand up for me and I was given a caesarean and I am still angry post natal – I was powerless”. The women’s experience under sub-theme “He talked too much” are described below.

4.7.2.4.1 Women's theme 4, sub-theme 1: He talked too much!

Some women found that the support person talked too much while the women did not expect or want them to do so. This was predominantly when the women in labour or after the childbirth process when the women felt very tired and needed to take a rest.

Woman 1: “My husband forced me to eat even though I had no appetite ... he kept talking and reminding me ... you might not be strong enough if you do not eat ... when the contraction came I pinched and pulled his hair ... when he talked ... **I instructed him to stop**... I closed his mouth with my hand ...”

Woman 13: “I expected that my husband would support me ... understand me... **did not need to talk too much** ... did not need to compare me with other women ... his sister ... **did not need talk too much**...the midwives said ... my husband said ... I’ve got stress ... confused ... even though there was no progress in the childbirth process... if I’ve got angry ... it seemed shy to the midwives ... After giving birth my husband said, “It’s been done” ... please stop... **did not need to talk too much** ... please go out ... please take a shower ... I’d like to sleep ... actually I felt pity to him ... he was fasting...

he hasn't eaten all the day ... could not sleep also ... I asked him to buy milk ... anyway, he went out... ”

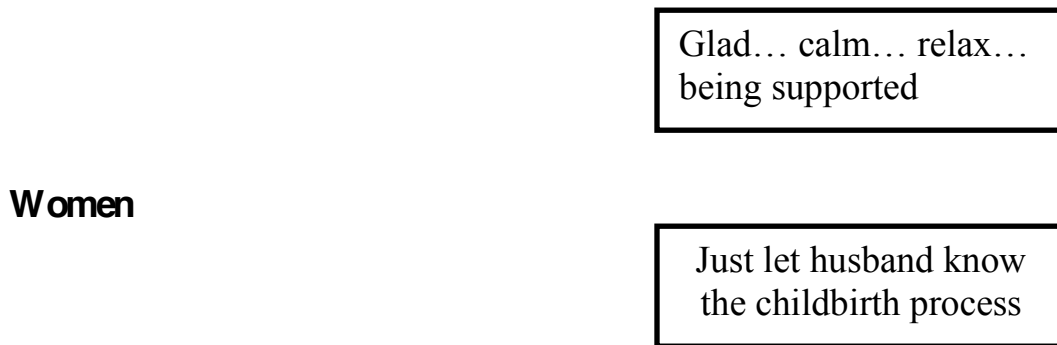
4.7.2.4.2 Women's theme 4, sub-theme 2: He didn't stand up for me and I was given a caesarean

Woman 45 felt she had no support from her husband when she had to have a caesarean childbirth due to her high blood pressure, even though she did not want it. She felt that her husband did not want to listen to her explanation. She said that she could not sleep at night. This was the reason why she had high blood pressure. She expected that her husband would be more assertive with the medical staff, and not just obey them. The woman's experience under the sub-theme “He didn't stand up for me and I was given a caesarean” is described below.

Woman 45: “When the doctor decided to do a caesarean because I had high blood pressure, I felt touched ... my baby would be forced to be born ... I felt angry, irritated ... I asked to go home ... but they didn't allow me (to go home) ... what a pity for my baby ... he was still tiny ... they told me that if things got worse, it would cost more money ... I felt good with my blood pressure ... however they advised me to have a Caesarean because of my high blood pressure to avoid seizures... Until now, I couldn't accept this decision ... my husband told me please don't cry ... this was the best way ... **I felt my husband didn't want to listen to me** ... the previous night I couldn't sleep well. It might cause the high blood pressure ... **My husband was not assertive with the medical staff.** He just obeyed whatever they said. He said that, it's OK doing Caesarean if it was the best way. **My husband should have been more assertive.**”

4.7.3 After – Women’s perception of support during labour and childbirth

Figure 36 presents themes in the women’s perceptions about their support during labour and childbirth (as reported after labour and childbirth).



Note:


 = Theme

Figure 36. Themes of perceptions of women about support during labour and childbirth (as reported after labour and childbirth).

4.7.3.1 Women’s theme 1: *Glad... calm... relax... being supported*

Following labour and childbirth, when women remembered and reflected on their experience of having a support person there, they recalled it positively. They felt support from their support person. They felt glad, calm, and relaxed having their support person during labour and childbirth. The women who had a previous childbirth experience reported feeling different about giving birth knowing they would have a known, trusted support person beside them during labour and childbirth. The woman’s perceptions about their support during labour and childbirth (as reported after labour and childbirth) under the theme “Glad... calm... relax... being supported” are described below.

Woman 13 chose her husband to be a support person to motivate her. She expected that her husband would accompany her when she felt pain. Because she was a scared woman, she expected that the husband would help her to control her feelings. She felt glad when her husband accompanied her during labour.

Woman 13: “**I was glad that my husband accompanied me...** *Alhamdulillah* (Islamic term to express praise be to God) my husband could accompany me ... (he said) it’s finished ... (since then) whatever you asked ... I would fulfil ... ”.

Woman 19: “My husband’s attendance influenced me positively during labour ... especially as this was the first child ... fear ... but there was only one person accompanied me... **I felt calm and relaxed** ...”.

Woman 33: “I felt glad because my husband accompanied me. He prayed *Sholawat* (a type of Islamic prayer)... If I suffered pain... there was someone who accompanied me... **calm**... It’s a different feeling when I was accompanied and not ... it was **more relaxed** when I was accompanied...”

4.7.3.2 Women’s theme 2: Just let husband know the childbirth process

Two women chose their husband as support person to let him know the childbirth process. The woman’s perceptions about their support during labour and childbirth (as reported after labour and childbirth) under the theme “Just let husband know the childbirth process” are described below.

Woman 13: “I chose my husband to motivate me as well as **to give him experience of the childbirth process**... Sunday morning I felt the water come through and then I called the midwife. The midwife said it might a vaginal discharge. On

Wednesday morning, it came through again. Without telling my Mum or others, I went to the maternity centre alone. The midwife still said the same that it might be a vaginal discharge because my weight is still the same, 55 kilo. There was a contraction. However, it might a fake contraction. But after the midwife had the depth check, it has been 1.25 opened and then I was asked to go to the childbirth room. I was so confused. I wanted to cry... very confused. I called my Mum... (the phone) was not picked up.. then I called my husband. He was shocked. He called my Mum and then my Mum came. I was given the uterine softener. When my husband came, the pain was very painful. I vomit... at 7pm I asked to have surgery... so tired... it hasn't been born... finally, my husband *tidak tega* then asking the midwife (to having surgery)... However, the midwife said that it could not be done because the baby's head has been on the bottom... when the childbirth came ... my husband supported me... come on, Dear... the head was seen... after the baby was born... I felt relieved... no pain anymore...”

Woman 33 also said that she wanted to be accompanied so that her husband would learn about the childbirth process. She felt calm and relaxed when her husband accompanied her.

Woman 33: “My husband was accompanying me ... but he looked at the wall.. he scare seeing blood.. he told... how pity my wife ...asked me to accompany... when the baby almost born he seemed be more pale and then the midwives offered him to exit... the midwife worried if he was not strong enough... for me it's OK... compared to mother, I prefer my husband as my support person so **he would know the process...**”

4.7.4 Two contradictory cases

Women 7 experienced support during labour and childbirth as extremely positive. She suffered toothache during her pregnancy. However, the toothache suddenly disappeared once she gave birth. She had a different experience during labour and childbirth in her current fourth childbirth compared to her previous experiences. This was the first time she was accompanied by her husband during labour and childbirth. She felt support from her husband. Her husband showed his empathy, consoled, massaged, and served her during labour and childbirth. Because of that she felt comfortable and strong, and she had never even felt as strong and healthy as she did in this current childbirth. This was the first time she experienced having lots of energy. She said, “It was more comfortable this time compared to my previous labour ... when I felt a little bit of pain ... I was massaged (by the husband) ... I didn’t ask... but it may be my husband thought that the pain would disappear (by being massaged)... I said pain ... heartburn ... he said ... yes ... it’s common like that ... please be patient ... hold just a moment ... I felt glad when my husband said that ... there was someone taking care (of me) ... so that he knew his role ... **I’ve never felt as strong as this** (during labour and childbirth) ... the previous ones were never like this ... **I didn’t even need stitches** ... I could feel the difference (feeling) ... (If I) felt pain ... there was someone to console (me) ... ”.

Her husband experienced that in the current labour and childbirth the woman did not scream while she screamed in the previous experiences. This might have been because, in the current experience, she was accompanied by her husband and this made her feel more relaxed. Her mind conveyed relaxing messages to the rest of her body, and so her body was aligned to this feeling of being more relaxed also. Her perineum was soft

which enabled a smooth birth. Because of that she did not suffer any tears and did not need to be sutured. This was the first time she gave birth without suturing. Her husband said, “I massaged her ... on the neck, shoulder... I *tidak tega* (Indonesian term meaning similar to *not fortitudinous*) to see her pain ... I’ve never imagined that the pain would be like that ... previous labour, she screamed very loud ... it might be because I was outside the room ... but now ... she didn’t scream ... because I was beside her ... It was my role to keep her calm .. she looked calmer ... she told me when she felt pain ... like that ... like that ... asked to call the doctor (midwife) ... I called the midwife ... made her calm... I was prepared to accompany my wife ... just accompany ... I must pray for her ... I could feel how she suffered pain ... if God gives us this many children ... I think is enough also ... (even though at the beginning husband 7 still wanted more children) ... I could feel how she suffered pain from her words ... she told me she was in pain frequently ... she felt *pasrah* (Indonesian term means submit to God’s will totally)”.

The midwife experienced that woman 7 was very cooperative, obeyed, during labour and childbirth because her husband accompanied her. Her husband played a very significant role to support the woman: held the woman’s hand and prayed. He was very helpful. The midwife said, “The woman obey ... was led throughout the birth ... her perineum was soft ... even **without suturing** ... only use of very little Betadine antiseptic liquid ... this is her gravida 4 ... Fourth pregnancy, third child”

Woman 19 encountered the opposite experience. Woman 19 expected to have her husband as her support person, but her husband did not dare to accompany her. Her mother also did not dare to accompany her and persuaded her to be independent during labour. Because of that, she said (to strengthen herself when she knew no one had any

intention to accompany her), “Should be calm anyway ... if scared ... all (muscles) will be contracted ... (the baby) cannot be born”.

Finally, the husband accompanied her during labour and childbirth because he knew that she needed support. However, her husband’s attitude did not reflect that he supported the woman. He laughed at the woman, compared her with his grandmother who was strong having seven children, and later told her mother that the woman was embarrassing during labour and childbirth because she screamed and did not obey the midwives’ guidance. After childbirth, her mother instructed her to apologise to all the midwives and the woman did so.

The midwife experienced that this woman did not have support from the husband or family during labour and childbirth even though the husband was beside her but did not give any significant support. The woman seemed to panic and did not focus on the midwife’s guidance. As a result, she pushed and then the baby was “jumping”. Woman 19 suffered a big rip in her cervix that needed the doctor’s intervention to enable recovery.

4.8 Research Question 2 – The Support Persons’ Perspectives

4.8.1 Before – Support persons’ perception about support during labour and childbirth

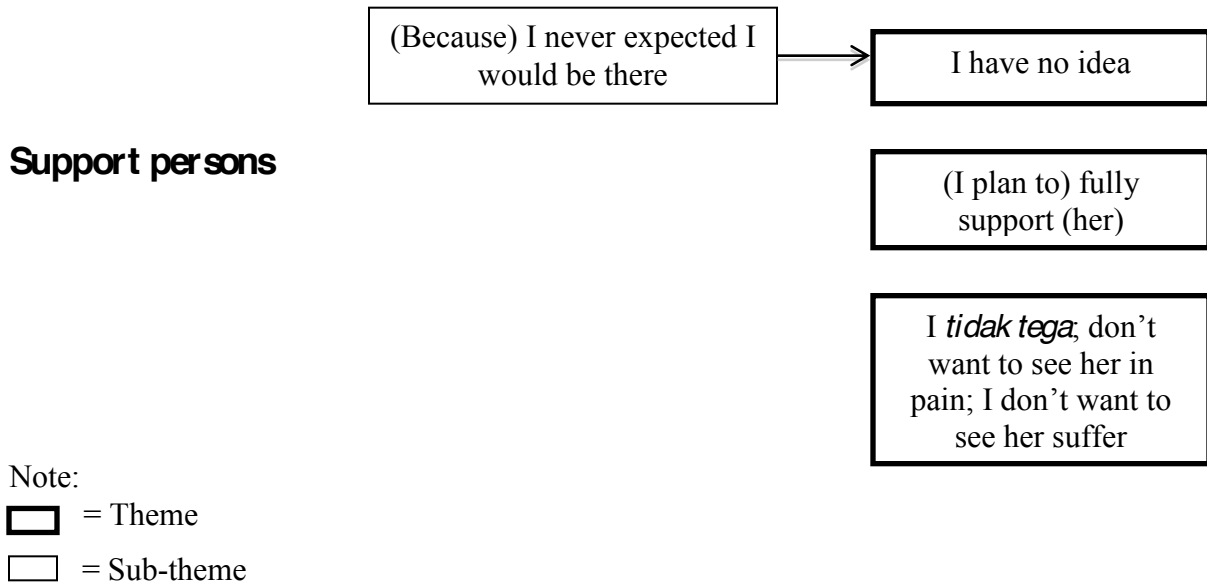


Figure 37. Themes and sub-themes of expectations of support persons about support during labour and childbirth (before labour and childbirth).

Figure 37 shows the themes and sub-themes of expectations of support persons about support during labour and childbirth (before labour and childbirth). Similar to the women’s response, the support person’s responses were quite short. The possible reasons for this phenomenon are described in Chapter 5. The support persons’ expectation about support during labour consists of three themes, of which one has a sub-theme. Each theme and sub-theme are described in the next sections.

4.8.1.1 Support persons' theme 1: I have no idea

Similar to the women, most of the support persons gave short answers when asked about their expectations of providing support during labour and childbirth. The possible reasons for this phenomenon are discussed in Chapter 5.

The support persons' theme of "I have no idea" could be interpreted as reflecting a sub-theme: "(Because) I never expected I would be there". This theme and sub-theme are described below.

4.8.1.1.1 Support persons' theme 1, sub-theme 1: (Because) I never expected I would be there

Many of the support persons had no idea about how the childbirth process might be because they did not expect to be there and had never thought about it. The support persons' expectations under sub-theme "(Because) I never expected I would be there" are described below.

Husband 13: "**I've never thought about the labour process ... because I've never known what it looks like** ... never seen in Youtube how the labour is ... just talking ... with sister ... with friend ... if by myself ... I've never accompanied ... if I should imagine ... I cannot ... never imagined ... even though I've heard about the experience ... I've never thought about it ... not yet".

Husband 16: "If **I think about it ... never** ... this ... euh ... for me this companion I want ... that it is not a burden ... that's pain ... and so on ... that is the risk ... but this is not a burden ... in Islam ... *sunnah* (Islam term means obligatoriness

(Haddad)).... I want my companion to be like ... if there is pain, that's what **the process should be like that actually...**".

Husband 26: "**Just follow the midwives' instruction** ... please just obey ..."

Husband 43: "**(I) Could not imagine** that I must accompany my wife ...".

4.8.1.2 Support persons' theme 2: (I plan to) fully support (her)

The second theme of husband's expectation is "(I plan to) fully support (her)". The support persons just planned to support the women totally. The support persons' expectations theme "(I plan to) fully support (her)" is described below.

Husband 1: "I will fully support her until the baby was born ... **I must support mentally...**".

Husband 2: "I'm still studying ... and at the time of the childbirth I will have a fieldtrip to Bali for five days ... that's why I worry that I cannot accompany her ... so every night I always say to the baby ... you must wait until I come ... so **I can accompany (you and the mother) and give fully support during childbirth ...**".

Husband 7: "I will **fully support her** ... just provide calmness ...so she will feel relaxed".

Husband 12: "**Support her fully...** I've ever had experience helping woman giving birth when I was a student ... so I knew how the process and will help the midwives guiding her during labour and childbirth".

Husband 18: "Want to accompany and **support her** so that I can know the childbirth process...".

Husband 24: “I might just accompany her... **give fully support** and pray maybe (laugh) Just *pasrah* (Indonesian term to express submit to God’s will totally or submit to anybody’s will totally or accept any condition that will happen totally ... in this context it could be trust the midwives totally...) to the midwives ...”.

Husband 30: “**I might just be there** when she needs ... even though I don’t talk... she can feel ... I am supported by my husband ... my attendance may support her psychologically...”.

Husband 33: “I don’t know what to do ... **just calm (her) ... fully support (her)** ... close my eyes while holding her hands...”

Mother 40 told, “**Just fully support ...**”

The second theme in the support person’s expectations is “(I plan) fully to support (her)”. Similar to the women, the support persons seemed difficulties in describing “how” they would give support. They seemed difficulties to describe the “concrete behaviour” they would provide.

It seemed that support persons might still have contradictory expectations about support during labour that was reflected in the third theme. The third theme of support person’s expectation is “I *tidak tega*, don’t want to see her in pain; I don’t want to see her suffer”.

4.8.1.3 Support persons’ theme 3: *I tidak tega; don’t want to see her in pain; I don’t want to see her suffer*

Many support persons felt ‘*tidak tega*’ (the best translation available for “*tega*” is that it includes both the speaker’s *compassion* and *strength* (translated as ‘*fortitudinous*’

in the direct quotations presented in this thesis. '*tidak tega*' can be translated as '*not strong*'): they did not want to see the women suffer pain during labour and childbirth. The support persons' theme of "I *tidak tega*, don't want to see her in pain; I don't want to see her suffer " is described below.

Mother 19: "I ***tidak tega*** ... don't want to see my daughter suffering in pain... much better if I don't know ... it's OK ... being independent ... there are midwives ... I am not brave ... I've visited a neighbour who suffered a broken (bone) ... I fainted ... I can feel (the pain) ... (I told my daughter that) it would be OK (that) she gave birth alone ... I believe that she will obey ... whatever the midwives instruct her ... (she will) obey ... please do not scream ... (she said) yes, Mum ... what for (should I) scream? ..."

Husband 20: "I support her ... ask her to pray ... asking for a smooth childbirth process ... I may be close to her head ... stroking .. so that she can stay calm ... hope the (childbirth) process is smooth ... not caesarean ... I worry about the cost (if caesarean) ... I worry also about my wife ... she is not brave ... (if she suffers) a little bit of pain ... crying (easily) ... in the past ... she had to stay in the hospital because of typhus ... (when she was) injected ... (she was) screaming ... **I don't want to see her in pain** ... I also cried ... (she will) be strong or not (in childbirth process) ... I worry ..."

Husband 33: "I don't know what to do ... just keep her calm ... support (her) ... **close my eyes while holding her hands...**"

Husband 42: "Support (her) ... give calmness ... if the midwife instructs her to breathe ... I will try to repeat the instruction ... I don't want to think about the down side... **I don't want to see my wife suffer pain** ... "

Husband 43: “Could not imagine that I must accompany my wife ... **I *tidak tega*** ... **do not want to see her suffer pain** ... However I should work against this feeling ... it might be if I am in the room, my love for my wife is bigger than my feelings, and so I do not want to see her suffer pain ... that’s why I try to be brave ...”

Husband 45: “**I *tidak tega*** ... don’t want to see ... **I don’t want to see her suffer pain** ... just support her ... pray ... hold her hands ...”

Husband 47: “Just support and pray ... I will accompany (her) ... I imagine **I may have pity on her** ... how hard a mother’s struggle is to give birth ...”

4.8.2 During – Support

about support during labour

persons’ perception

and childbirth

I had a new appreciation
for what it takes to give
birth

I gave my full support

Support persons

I took action to try
and end her pain and
suffering

Note:


 = Theme

Figure 38. Themes of perceptions of support persons about support during labour and childbirth (as reported 1-2 days after labour and childbirth).

Figure 38 shows the themes of perceptions of support persons about support during labour and childbirth (as reported 1-2 days after labour and childbirth).

Most of the support persons “*tidak tega*” witnessed the women fighting pain by herself and they felt they could not do anything to help reduce the pain. As a result, they just kept silent when the women did anything to harm him/her. They just supported the women through their difficult time.

In general, most of the support persons in this study had a positive perception of their support during labour and childbirth. Three themes emerged from the support persons’ experiences about support during labour and childbirth. They were: I have a new appreciation for what it takes to give birth, I gave my full support, I took action to positively end her pain and suffering. Each theme is described below.

4.8.2.1 Support persons’ theme 1: I have a new appreciation for what it takes to give birth

Some husbands reported feeling enlightened after seeing the childbirth process, having seen how hard their wife struggled during labour and childbirth. The support persons’ experience under the theme “I have a new appreciation for what it takes to give birth” is described below.

Husband 1: “**I *tidak tega* to her** ... I prayed and supported her during labour ...each time after the midwife check up my wife, I always ask how the progress and concern about the progress when we need to decide to do caesarean or not ... because I remembered my experience regarding to my grand mother in the past that was too late to do surgery and then she was died.... ”

Husband 7: “I massaged her ... on the neck, shoulder... I *tidak tega* to see her pain ... I’ve never imagined that the pain would be like that ... previous labour, she

screamed very loud ... it might be because I was outside the room ... but now ... she didn't scream ... because I was beside her ... It was my role to keep her calm .. she looked calmer ... she told me when she felt pain ... like that ... like that ... asked to call the doctor (midwife) ... I called the midwife ... made her calm... I was prepared to accompany my wife ... just accompany ... I must pray for her ... **I could feel how she suffered pain ... if God gives us this many children ... I think is enough** also ... **(even though at the beginning husband 7 still wanted more children)** ... I could feel how she suffered pain from her words ... she told me she was in pain frequently ... she felt *pasrah* (Indonesian term means submit to God's will totally)"

Husband 13: "**I tidak tega** (Indonesian term means similar to not strong) to see her suffer in pain ... and told her that **if she only wanted one child that was OK ... just one child (even though at the beginning husband 13 wanted to have 7 children)** ..."

4.8.2.2 Support persons' theme 2: I gave my full support

As their expectation, the support persons provided their full support to the women during labour and childbirth. The support persons' experiences under theme "I gave my full support" are described below.

Husband 1: "**I supported her until the baby was born.** I tried to prepare her body to be strong. I read some literature that she needed a lot of energy. She had to have energy reserves. The energy came from food. Because of that, I forced her to eat. If she didn't want to eat rice, she must finish the bread. Finally, she finished the bread and egg. I felt anxious when she didn't want to eat. I was afraid she wouldn't be strong enough. I forced her to eat for her welfare. Actually I wanted her to eat as much as she could, but I

also felt pity for her. **I must support her** mentally with prayer and spirit. Before that process, I asked her to relax.”

Husband 13: “Some midwives were good, gave support. **I provided my full support for my wife.**”

Mother 10: “I hold her hand ... she looked calm ... **I supported her with my prayer** ... she could hear ... she followed ... then *Allahu Akbar* (term in Islam means God is the Greatest) ... the baby was born...”

Mother 27: “I *tidak tega* to see my daughter ... how pitiful she was... **I fully support her** and told her ... be patient ... be patient ... childbirth is commonly painful like that ... however when the baby was born the pain will be gone ... she looked more relaxed ... take breath ...”

Husband 2: “**I supported my wife with prayer** ... I encouraged her ... actually she was scared when she had to have a caesarean ... but I told her ... it’s OK ... just passed it ... I kept her calm ... this is the moment that we have been waiting for for so long ...”.

Husband 41: “I talked to my wife ... laugh ... if I asked a question ... it should not be answered ... the most important thing was **giving support** ... actually I wanted to accompany her in the surgery room ... but it’s OK ... the most important thing was my wife and my child were safe ... just surrender ... trust the doctor ... I prayed for the best during the caesarean process outside the surgery room.”

4.8.2.3 Support persons' theme 3: I took action to try and end her pain and suffering

When *tidak tega* seeing their wives suffered pain, two support persons (husbands) tried to end their wife's pain by asking the midwives about the possibility of doing a caesarean. The support persons' experience under the theme "I took action to try and end her pain and suffering" are described below.

Husband 1: "I asked the midwives ... when will my wife be induced? ... **There should be a time limit for deciding between a caesarean or normal childbirth.** The midwives told me that it depended on the doctor who would make a decision. Every time after the midwife observed my wife, I asked if there was any progress. When was the time limit to make a decision about having a caesarean or normal birth because the next day was Sunday? I was worried that there may be no doctor on Sunday."

Husband 13: "I *tidak tega* to see her suffering pain and vomiting. **I asked the midwives to do a caesarean.** However, the midwives said that they could not do a caesarean because the baby's position has been on the bottom [too far down in the birth canal]. I told my wife that the midwives said it's close to being born."

4.8.3 After - Support person's perceptions about support during labour and childbirth

Similar to the women, even after labour and childbirth, most support persons remembered it positively, and particularly the husbands. Some husbands also observed, compared to their wives' accounts of their previous birth experiences, that the women seemed calmer and more relaxed.

Figure 39 presents the themes and sub-theme of perceptions of support persons about support during labour and childbirth (after labour and childbirth).



Note:

= Theme

= Sub-theme

Figure 39. Themes and sub-theme of perceptions of support persons about support during labour and childbirth (after labour and childbirth).

4.8.3.1 Support persons' theme 1: Fully support

The support person tried to provide their full support when they accompanied the woman during labour and childbirth. They felt grateful that they could accompany the woman during labour and childbirth. They also developed their empathy when they saw the woman suffering pain during labour.

4.8.3.1 Support persons' theme 1, sub-theme 1: I have a new appreciation for what it takes to give birth

The support persons (husbands) reported how enlightening it was to witness the women struggle during labour and childbirth. The support persons' perceptions about

their support during labour and childbirth (as reported after labour and childbirth) under sub-theme “I have a new appreciation for what it takes to give birth” are described below.

Husband 7: “The most impressive experience was the time accompanying the woman. During that time I could really feel the woman’s pain before childbirth. I’ve never had that experience before. **If it’s right that God gives us the right number of children ... it’s OK ... I could feel how pain is ...** from my wife’s words ... she said it hurt intermittently ... she seemed to give up ... the most important thing was (the baby) can be born ... I just gave support ... please, be patient ... She was not stitched... had not been torn. This is the first time she was not stitched ... I was very grateful that I could accompany my wife during labour... ”

Husband 13: “**If she didn’t want (to have any children again) ... it’s OK if we have only one child ...** we don’t need to have any more children ... **I didn’t want to see her suffering pain ...** after she gave birth I told her that I will never leave her again ... I will fulfil whatever she asks ...”

4.9 Research Question 3 – The Midwives’ Perspectives

4.9.1 During – Midwives’ perception about support during labour and childbirth

Midwives

The support person helped
me to support the woman

Note:


 = Theme

Figure 40. Theme of perceptions of midwives about support during labour and childbirth (as reported 1-2 days after labour and childbirth).

Figure 40 shows the theme of perceptions of midwives about support during labour and childbirth (as reported 1-2 days after labour and childbirth).

All the midwives in this study had positive responses regarding the support provided during labour and childbirth. They experienced that the support persons helped them to reduce the women's anxiety during the labour and childbirth.

4.9.1.1 Midwives' theme 1: The support person helped me to support the woman

One theme of the midwives' experience about support during labour and childbirth was: The Support Person Helped Me to Support the Woman. The midwives' experiences under theme "The support person helped me to support the woman" are described below.

Midwife 12: "At the beginning the woman who was induced was screaming because the husband was not there and no-one knew where he was. The husband asked permission from the woman to sleep for an hour because he was very tired after working a night shift at the hospital. The staff tried to persuade the woman not to scream so she could save her energy. However, it was not successful. The woman still screamed... when the husband came to the labour room, **he was really helpful**... the woman seemed more relaxed. After that the woman wanted the drink that was served by her husband."

Midwife 26: "The woman had no voice. Usually women scream because the induction is very painful. If we have 10 pregnant women like that I am very glad (laugh)... her pain threshold was very high... most women usually have screamed because it is painful to be induced. **Her husband was very good at providing support to the woman.** He mostly laughed with us also. Like a family."

Midwife 10: “**The woman was very cooperative because her mother was there** ... seemed more comfortable ... her pushing was very good ... her mother was good to support her ... seemed confident ...”.

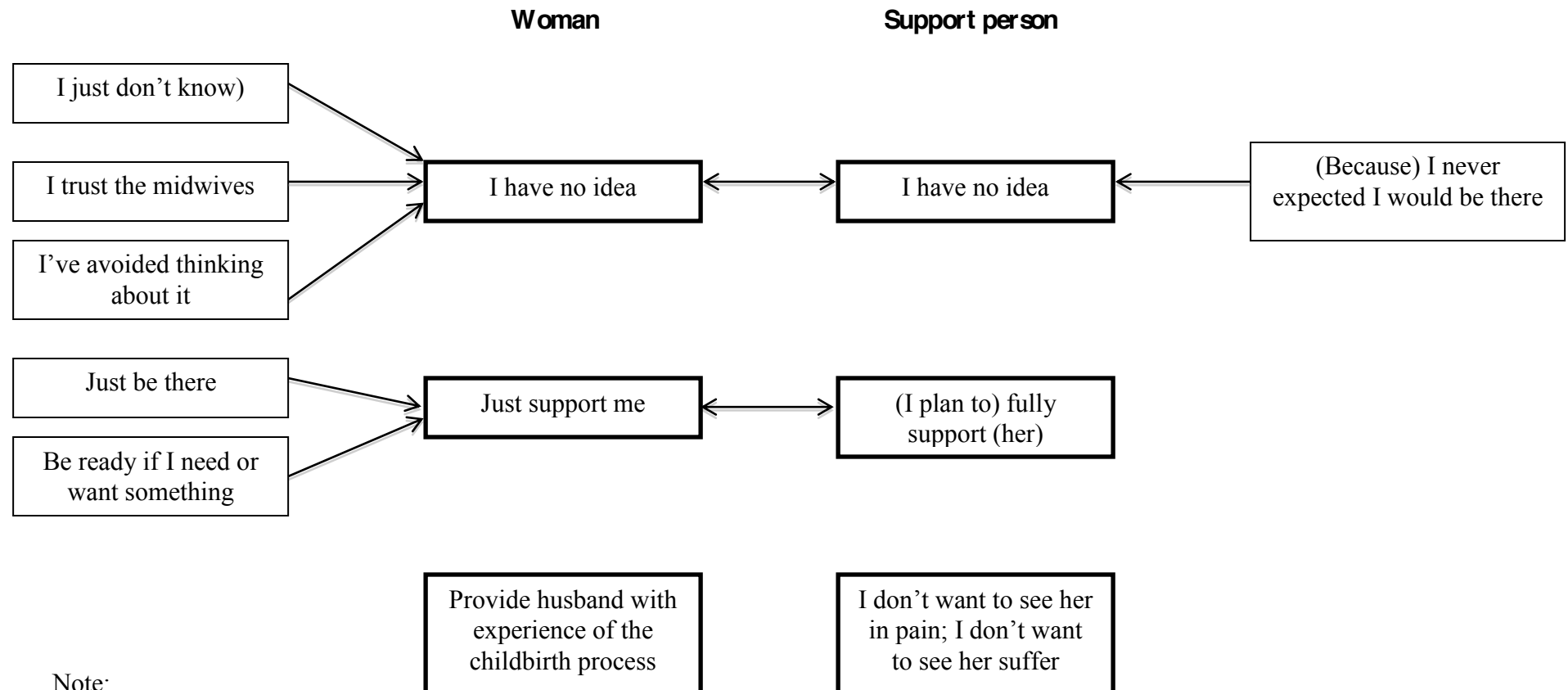
Midwife 27: “**Her mother was good.** She prayed beside the woman. When the midwife told the woman not to push ... her mother repeated it for the woman ... the mother encouraged the woman very much ... the woman was very cooperative....”

Midwife 40: “Her mother was there. **Her mother supported the woman so the woman felt calm.** Her mother prayed. Because of that the woman seemed calm.”

Midwife 41: “**The husband was really great** ... the woman was calm because of the husband ... so even though it’s painful, she didn’t feel it... the husband was taught that if his wife felt pain ... put her hand on the wall ... then stroke her back ... and he did it ... her husband was very good while accompanying his wife. That’s why his wife didn’t feel pain at all.”

4.10 Comparing perspectives before labour and childbirth

The similarities and differences between the women’s and the support persons’ expectations regarding the provision of support during labour are presented in Figure 41.



Note:

▮ = Theme

▭ = Sub theme

Figure 41. Themes of expectations of women and their support person about support during labour and childbirth (before labour and childbirth)

Most women and support persons stated, “I have no idea” about what sort of support should be provided during labour. From the support persons’ perspectives, this theme had just one sub-theme: (because) I never expected I would be there. By contrast, from the women’s perspectives there were three sub-themes.

Similar to the women, most support persons (62%) in this study could not describe what sort of support they were expected to provide to the woman. They said that they would only support the woman during labour and childbirth without a more detailed description. They also said that they trusted the midwives who were the experts to help the woman. This was stated by ten of fifteen support persons of women who had normal childbirth and three of six support persons of women who had caesarean deliveries.

Despite these similarities, with further probing some differences in the “I have no idea” expectation emerged between women and their support person. These differences are described below, starting with the women’s sub-themes: ‘I just don’t know’, ‘I just trust the midwives’, and ‘I’ve avoided thinking about it’.

4.11 Comparing perspectives during labour and childbirth

This section describes how the women, support persons, and midwives experienced the support during labour and childbirth.

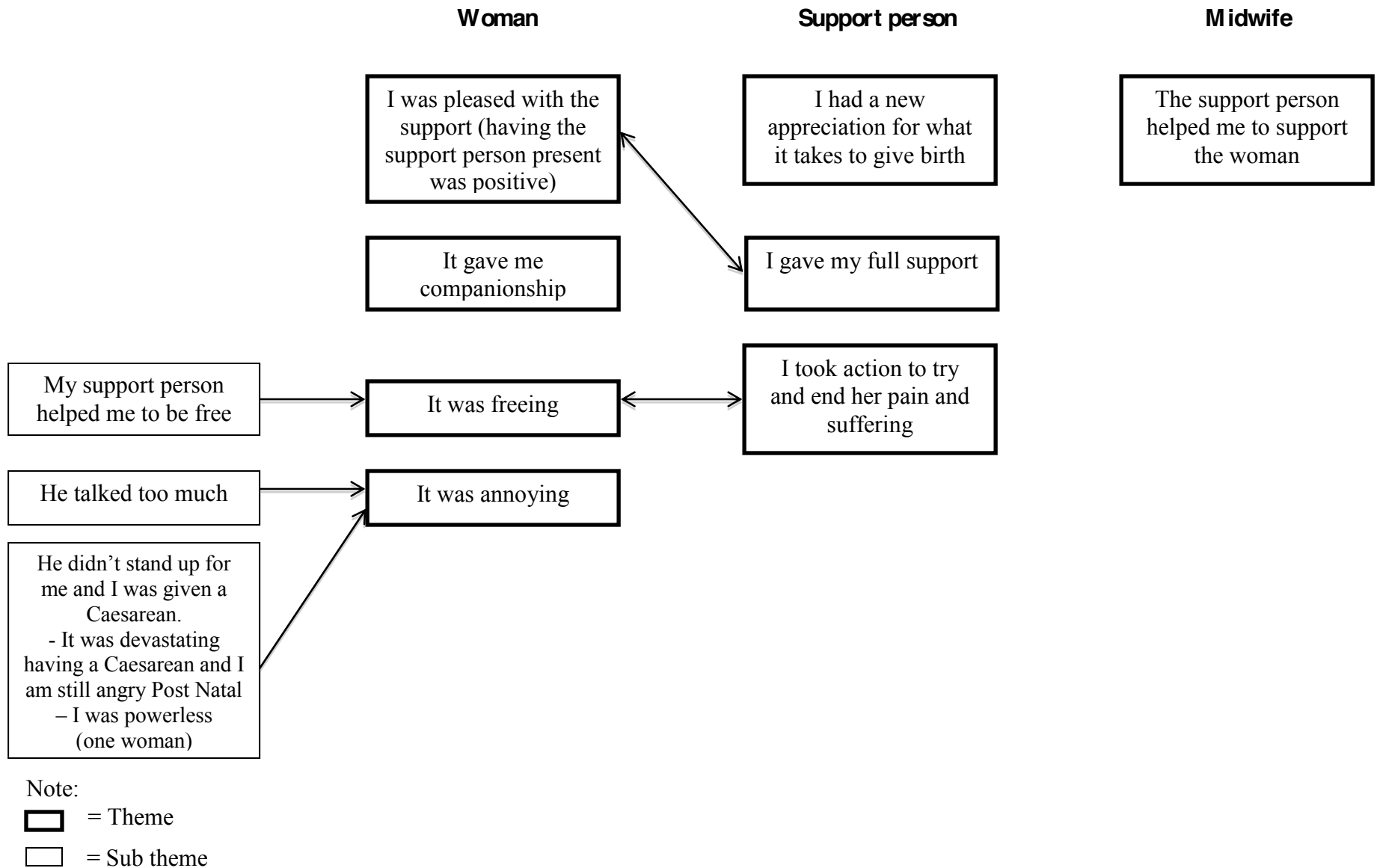


Figure 42. Themes of perceptions about support during labour and childbirth for the women, support persons, and midwives

With respect to perceptions about support during labour and childbirth, four themes emerged from the women's experiences, three themes emerged from the support persons' experiences, and one theme was apparent in the midwives' experiences (Figure 42).

In general, there was a similar perception about support during labour and childbirth between women, support persons, and midwives. With the exception of one woman, all the women support persons, and midwives all stated the provision of support during labour and childbirth was a positive contribution. This included one woman who regarded the provision of support as a positive aspect of the birth process, even though she herself was provided with little effective support.

4.12 Comparing perspectives after labour and childbirth

Before labour and childbirth, the women had few expectations, trusted the midwives, avoided thinking, just wanted to be supported, and wanted their husband to experience the childbirth process when they were asked about their expectations during labour and childbirth. During labour and childbirth, the women were pleased to have the support person who gave them strength. They also appreciated being accompanied and felt free having the support persons during that period. However, some women also felt that their support person was annoying because the support person talked too much or did not stand up for her when she was advised to have a caesarean by the doctor. After labour and childbirth, the women confirmed the experience of having the support person during labour and childbirth in that they felt glad, calm, relaxed, and had a different experience during this labour and childbirth.

Similar to the women, before labour and childbirth, the support persons had no idea about support during labour and childbirth because they were never expected to be there. However, they expected to fully support the women even though they did not want to see the women suffering pain. During labour and childbirth, the support persons had a new appreciation for what it took to give birth. They also gave full support and took action to try and end the women's pain and suffering during that time. After labour and childbirth, the support persons confirmed their full support and a new appreciation for what it took to give birth when they were asked about their experience during labour and childbirth.

During labour and childbirth, the midwives experienced that the support persons helped the midwives to support the woman.

4.13 Summary

This chapter presented the findings of the study. It described the demography, profile, and expectations and experiences of having support during labour and childbirth of the women, support persons, and midwives before, during, and after labour and childbirth.

Before labour and childbirth, the women had no clear expectation of the support that they might receive or the impact it might have. While placing their trust in their midwives and avoiding thinking in detail about the nature of the support they might receive, the birthing women welcomed the prospect of being supported and thought it would provide their husbands with valuable experience of the childbirth.

During labour and childbirth, most of the women were pleased to have the support person present to give them strength and appreciated having a person who was happy for them to give voice to their pain and discomfort. Without that support, several women would have tried to stifle their screams as a mark of respect for their midwife or as a way of conserving their energies. Some women also felt that their support person was less than optimally effective because that support person talked too much or did not advocate for the women's interest, particularly when the doctor decided on a Caesarean birth. After labour and childbirth, the women confirmed that having the support person present during labour and childbirth meant they felt glad, calm, relaxed, and overall they had a different experience during this labour and childbirth.

Prior to being present at the labour and childbirth, the support persons had no idea about what expect. Despite never having previously expected to be present during the labour and childbirth, and some concerns about seeing the women in pain, they were committed to supporting the birthing women.

During labour and childbirth, the support persons gained a new appreciation for what was involved in giving birth. Most provided effective support and acted to minimise the women's pain and suffering during that time. When asked afterwards about their experience during labour and childbirth, the support persons recalled providing effective support and gaining a new appreciation for what was involved in giving birth.

The midwives reported that the support persons had helped them to support the birthing women during labour and childbirth.

The discussion of the findings is provided in the next chapter.

CHAPTER 5: DISCUSSION

5.1 Introduction

The previous chapter presented the findings of a narrative inquiry investigating how women giving birth, their support person and midwives viewed the provision of intrapartum support for childbearing women by a known and trusted layperson. This chapter considers and discusses those findings in the context of the material presented in Chapter 2 regarding the theoretical models of health, wellness and psychology and the published research literature on the value of intrapartum support for childbearing women. The findings are considered against the biopsychosocial model of health psychology and cognitive psychology, and in relation to existential and humanistic psychology. The challenges of conducting this research, and of obtaining meaningful data, as well as the meaning of some of the findings, are positioned in the context of what is known about Indonesian culture, values and norms.

Consistent with the tenets of narrative inquiry, this chapter considers chronology of the participant women's childbearing trajectory, describing the perceptions of women and their support person in chronological order (before, during, and after labour) to explore their experiences more fully. It discusses women's expectations of what it would be like to be supported in labour, the support persons' expectations of what providing support would comprise, and what each person wanted from the experience. It then discusses the meaning of women's, support persons', and midwives' experiences of the

presence of a lay support person during labour and birth, as well as their reflections on its value.

This chapter thus describes the expectations and experiences of support people during childbirth from three points of view - that of the women, the support persons, and the midwives. The discussion in this chapter considers the commonalities of the participants' experiences and explores some individual cases, which highlight key findings.

5.2 Overview

According to the health psychology approach, particularly the biopsychosocial model (Borrell-Carrió et al., 2004; Sarafino & Smith, 2011; Saxbe, 2017), it is important to understand a woman's biological, psychological, social, and cultural context to understand the woman's needs. The women in this study received support from their spouse, families, friends, colleagues, neighbours, and midwives during their pregnancy and after giving birth. The community supported the pregnant women by according them respect in ways such as providing space for them to walk when they were in a public space and the *Tingkeban* traditional ceremony held at the seven month mark of their pregnancy (Bratawidjaja, 2000).

Support reached its peak during labour and childbirth when the women had their support person beside them. Based on the women's, support persons', and midwives' stories about support during labour and childbirth, in general, it can be concluded that the presence of a support person had a positive impact on the women's ability to relax, feel comfortable, experience positive emotions and experience an easy childbirth process,

whether by normal birth or caesarean. This was also confirmed by the midwives and support persons.

5.3 A Holistic Understanding of Support during Labour and Childbirth

Biopsychosocial theory argues that the psychological and social aspects of women in childbirth influence the biological aspects of childbirth (Perry et al., 2010; Saxbe, 2017). Reducing anxiety and helping birthing mothers relax through social and psychological support can limit the increases of catecholamines which in turn, decreases blood circulation to the uterus and reduces uterine contractions (Batbual, 2014, Saxbe, 2017). This reduction in these physical effects leads to easier childbirth.

In this study, the presence of their support person enabled the women to relax and their midwives to observe the effect of the support on the birthing women. This experience is reflected in the womens' themes: 'I was pleased with the support (having the support person present was positive), and 'It gave me companionship', 'It was freeing'. These women's themes are compatible with the support persons' themes: 'I have a new appreciation for what it takes to give birth', 'I gave my full support', and 'I took action to try and end her pain and suffering'. Both women's and support persons' positive experiences were reflected in the easy childbirth that the women experienced.

These findings aligned with previous studies showing that the presence of a support person benefits women during labour and childbirth, eases the birth process and enhances the birth experience (Astutik & Sutriyani, 2017; Baker, 2010; Defiany et al., 2013; Diponegoro & Hastuti, 2009; Dlugosz, 2013; Hodnett, Gates, Hofmeyr, & Sakala,

2013; Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011; Kartini, 2011; Klaus et al., 1986; Lailia & Nisa, 2015; Primasnia et al., 2013; Reynolds, 1988; Torres, 2015).

This study broke new ground by showing that midwives also found the presence of a support person had a positive impact. This was reflected in the midwives' perception that 'The support person helped me to support the woman'. The presence of a support person did not just assist the women to feel relaxed but also helped the midwives to assist the women in giving birth.

Furthermore, the theme of the support persons' experience about support during labour and childbirth was 'Fully support'. Consistent with the support persons' expectation that they would provide full support to the women, they were grateful postnatally that they could do so. This experience gave them new insight. Underlying this theme is the sub-theme: 'I have a new appreciation for what it takes to give birth'. Having witnessed birthing women struggling with pain and risk of death, they understood how the women suffered during labour and in some cases reconsidered their previous plans to have many children.

According to Rogers (2004), trustworthiness plays an important role in helping relationships. In this study, trustworthiness was the key to understanding the women's relationships with both their support person and the midwives, but was most significant in the relationships between the women and their support persons.

In this study, the women's perceptions of their support person's intentions and attitude were based on observations of their behaviours. When the support persons demonstrated attentive and positive behaviours, the women felt the *attention* and

perceived an *intention* to provide support. Behaviours perceived as empathetic and supportive included:

- providing verbal support (e.g., providing verbal motivation, verbal encouragement, chatting);
- praying with or for the birthing mother;
- providing supportive touch (e.g., stroking, holding hands, massaging);
- interacting with midwives (e.g., calling the midwives, discussing the women's condition with the midwives); and,
- other forms of practical support (e.g., feeding her hospital meals, helping her to find a more comfortable position, reminding her of the recommended breathing techniques).

Touching (such as stroking) stimulates the mechanoreceptors in the skin which, according to the gate control model of pain perception as described in Chapter 2, sends nonpainful tactile stimulation to the gate (Goldstein & Brockmole, 2017). It might explain why, therefore, the women felt less pain and relaxed (Field, 2010; Goldstein & Brockmole, 2017). Field (2019) reviewed many studies from the US, Brazil, Japan, Spain and Germany and found that touching from a partner reduced stress. She found that holding hands and hugging strengthened relationships, particularly between partners. This might also explain the findings in this study that all the women preferred their husband as their support person during labour and childbirth because it might strengthen their relationship as a couple.

The women perceived the provision of support and the intention to provide support as evidence of both the *meaning and value* the support person placed on the woman and the childbirth process and the trustworthiness of the support person. The

nature of the support provided was less significant than the presence of a person intent on providing ongoing support throughout the process of labour and childbirth.

5.3.1 Extent of support for women during labour and childbirth

Based on the findings, the nature of the support for the women during labour and childbirth can be categorised into three types:

1. Effective (18 cases).
2. Less than optimally effective (two cases).
3. Counterproductive (one case).

Theoretically, the presence of a support person might have no impact, but no cases of neutral impact was observed in this study.

In Category 1, the women felt comfortable receiving support from their support person and the labour and childbirth process was easy for these women. Their perception of the effectiveness of support depended on their perception of the *intention* and attitude of the support person, with a positive attitude linked to the *attentive* and positive behaviour by their support persons.

Effective support occurred when the support person:

- a. demonstrated trustworthiness, congruence (among the awareness, experience, and communication),
- b. used positive words to provide support and encouragement,
- c. performed positive empathetic behaviours, such as talking, engaging in prayer, stroking, holding hands, massaging, feeding, serving, helping the woman to find a comfortable position, guiding the women to take a breath, calling the

midwives, discussing the women's condition with the midwives, and even remaining silent when the women harmed them (e.g., squeezed, pinched, closed his mouth, and tore his shirt).

In Category 2, the women still felt comfortable receiving support from their support person and the labour and childbirth process was easy for these women. The *intention* and attitude of the support persons again influenced the effectiveness of the support they provided. The *intention* of support was reflected by a positive attitude, which was reflected by the *attentive* and positive support persons' behaviour, and a silent presence.

Less than optimally effective support occurs when there is a mismatch between the support the woman desires and the support that the support person provides. The optimal form of support will vary from woman to woman, and may include some behaviours that the support person is unwilling or unable to provide for reasons relating to their personality (not demonstrative) or skills (e.g., they may lack massage skills) or situational reasons (being too exhausted to stay awake). In reported cases of less than optimally effective support, the support person was:

- a. overly talkative (as in the case of woman 13),
- b. offering less than the desired verbal (and non-verbal) support during labour and childbirth.

The only woman in Category 3 felt uncomfortable receiving support from her support person during the labour and childbirth process. This woman probably perceived a lack of *intention* to provide support suggesting her support person was unable or unwilling to focus on the importance of the woman and her support needs. His attitude

was negative, which was reflected by his evaluations and judgement of the woman who he had volunteered to support.

Counterproductive behaviour happens when the support person:

- a. seems untrustworthy or lacking in congruence,
- b. uses negative words: comparing with others, scolding, and evaluating words,
- c. exhibits negative behaviours, such as laughing at the woman.

5.3.2 Normal births

This study provided evidence that the women and their support persons grew in a personal sense because they were in trusting relationships throughout their experience of labour and childbirth. This accords with Rogers' (2004) finding that individuals could grow in a personal sense when they were in a trusting relationship with a therapist or counsellor regardless of the psychotherapy approach used to provide support.

Figure 43 summarises each participant's perspective and the comprehensive understanding of support during labour and normal childbirth. This figure illustrates the holistic understanding regarding the experience of support during labour and normal childbirth based on the women's, support persons', and midwives' stories. It shows where support persons could be classified as:

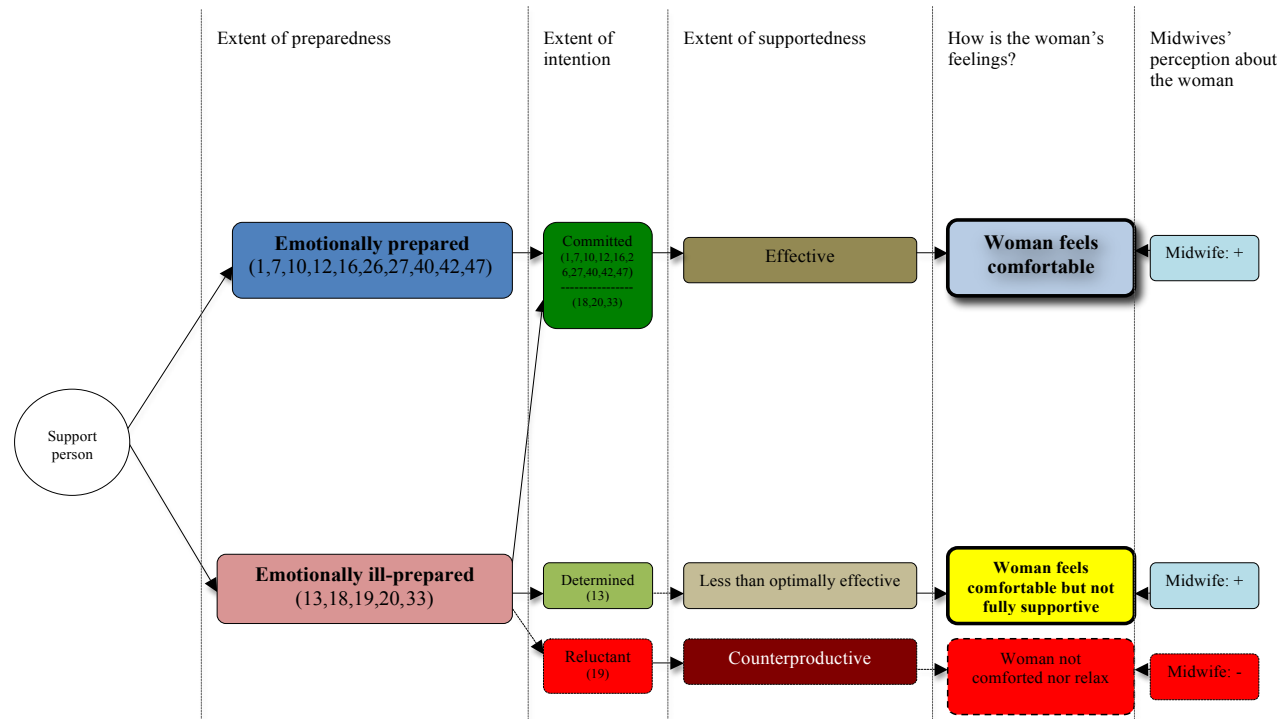
- effective,
- less than optimally effective,
- counterproductive,

and into two categories:

- emotionally prepared and

- emotionally ill-prepared.

Normal birth



Note:
- Number indicates the participant's number.

Figure 43. A taxonomy of support persons involved in the normal birth.

Support persons who were emotionally prepared (support persons of women 1, 7, 10, 12, 16, 26, 27, 40, 42, & 47) provided effective support for the women during labour and childbirth through the supportive behaviours discussed earlier in this chapter. The women perceived these support persons as congruent and trustworthy and valued both their commitment to accompany the women during labour and childbirth and their supportive attitude, feelings, words, and their behaviour demonstrated throughout the pregnancy.

These positive psychological aspects and behaviours were considered to reduce the perceived pain of labour by helping the women relax, providing a distraction from the pain of labour, and motivating and encouraging the women. Women felt that the presence of these support persons enabled them to remain more comfortable and relaxed during labour and childbirth. This finding aligns with those of previous studies (Astutik & Sutriyani, 2017; Baker, 2010; Defiany et al., 2013; Diponegoro & Hastuti, 2009; Dlugosz, 2013; Field, 2010; Kartini, 2011; Klaus et al., 1986; Lailia & Nisa, 2015; Langer et al., 1998; Primasnia et al., 2013; Reynolds, 1988; Torres, 2015). While none of these studies explored the midwives' experiences, the midwives in this study confirmed that the presence of these effective support persons helped the women to feel more comfortable and relaxed. Having positive attitudes and less pain enabled the women to more fully cooperate with their midwives and thus made the childbirth process and the midwives' work easier.

While all of the effective support persons were committed, they differed in the extent of their emotional preparedness. The committed support persons (of women 18, 20, & 33) were able to effectively support the women despite feeling emotionally ill-

prepared. This accords with Rogers' findings (2004) that the effectiveness of helping relationships depends on the attitude of the individuals involved. The positive attitude of these support persons reflected their intention to provide effective support. According to May (1965), intention means attention focused on something meaningful. Here a focusing on the women's needs for support and their relation with that woman enabled these support persons to move beyond focusing on their own sense of being emotionally ill-prepared. In Chapman's (1995) terms, these were loving individuals trying to express their love to a beloved person by serving them in an unselfish way.

While the intention to support the women during labour and childbirth was more important than a support person's perceived lack of information, the support provided did not always match the support desired by the birthing mother. The support person of woman 13 was less than optimally effective, but did support his wife via a range of empathetic, supportive behaviours. While the congruence of his attitude, feelings, words, and behaviour allowed his wife to feel comfortable during labour and childbirth, she would have preferred him to be less talkative, and resented his mentioning his sister's and mother's experiences of childbirth in a misguided attempt to motivate and comfort her. While this husband disregarded his wife's request to talk less and made some unwelcome remarks, she considered that overall he had provided effective (if less than optimal) support for her. Midwives confirmed that this woman's support person had helped her relax sufficiently that her relaxed condition helped her during labour and childbirth, making the midwives' work easier.

Where a support person's lack of knowledge led him or her to behave at times in incongruent, non-supportive ways, the birthing women felt annoyed or misunderstood

rather than supported. Better briefing and training could enhance the effectiveness of support persons by raising their awareness of behaviours that might annoy the birthing woman and reduce her ability to relax.

Only in one case (woman 19) did the presence of a designated support person prove counterproductive, not only failing to support the birthing woman in her view, but actually made her childbirth process more difficult. Here the birthing woman was aware for some weeks of her husband's reluctance to support her during labour and childbirth. His unhelpful behaviours during the birth process included laughing at his wife's experiences of pain and comparing her unfavourably with female relatives who had many children. After giving birth, her husband told her mother that his wife had been embarrassing as she had screamed throughout the labour and childbirth. The mother asked her to apologise to the midwives, which she did.

Rogers (2004) emphasised that only the individual can know himself/herself precisely and may, therefore, be disturbed or upset by others who evaluate or judge them negatively even though they can only perceive "a sample" of that individual's life. Woman 19 sadly appeared subject to ongoing negative judgements from both her husband and mother.

The incongruence in the attitude, feelings, words, and behaviour of her designated support person may however have impeded woman 19's ability to relax and focus on the midwives' guidance for a variety of reasons. As this woman was unsupported and even negatively judged by her support person, she may have felt her support person was not trustworthy and appeared to lack *any intention* to support her. His unwillingness to pay *attention* to her and her evident pain suggests she had *little meaning* to him other than as

a reflection of his family. She may have felt that a husband should pay attention to his wife because in Javanese language, the closest relationship between a husband and wife is encapsulated with the term *garwa* (a short form of *sigaraning nyawa*), meaning the split of the soul. For this woman, a better option might have been either to have no support person or to have effective support from a volunteer or professional support person who was neither the woman's husband or mother.

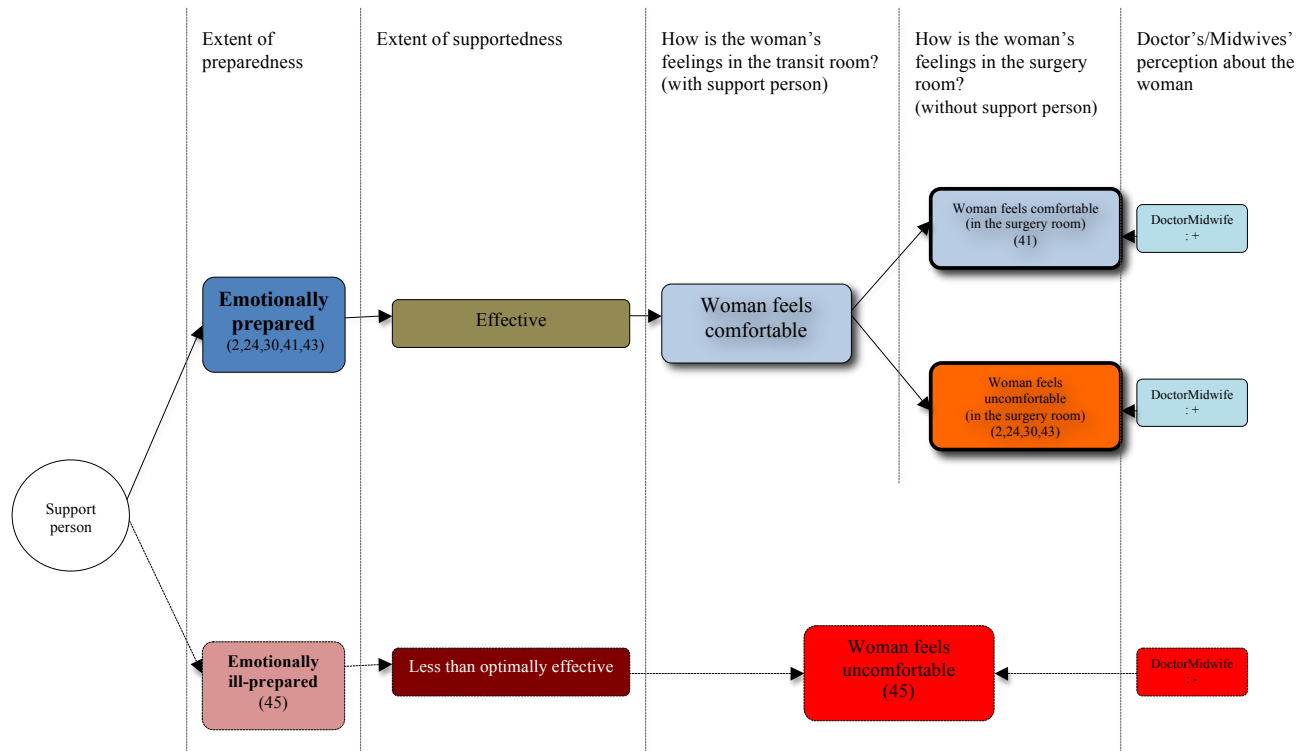
This case suggests that from both the woman's and the midwives' perspectives, the support person who is both emotionally ill prepared and reluctant cannot offer effective support and their presence during labour and birth may be damaging to the person they are supposed to support. This in turn suggests that a woman who has neither a husband nor a mother prepared and committed to act as her support person during childbirth might prefer to have some other emotionally prepared and committed volunteer to act in this capacity, or manage without a support person. Recruitment and training and supervision of support persons need to take account of this. To safeguard the mother's health and aid the birth process, midwives and birthing mothers should be able to exclude any counterproductive support person from the birthing chamber.

5.3.3 Unplanned caesarean birth

As with the normal births, the support persons of the women having caesarean births played an important role in supporting them during labour and before childbirth. The perceived congruence of the support persons' attitude and trustworthiness allowed the women to feel comfortable and relaxed, particularly during labour and preparation for caesarean. Figure 44 summarises the "whole picture" of the experience relating to

support during labour and before childbirth in caesarean women based on the women's, support persons', and midwives'/doctors' stories.

Caesarean



Note:
- Number indicates the participant's number.

Figure 44. A taxonomy of support persons involved in caesarean childbirth.

Effective support was provided by the emotionally prepared support persons (of women 2, 24, 30, 41, & 43) who intended to support the women during labour and before childbirth. These support persons effectively supported the women until they moved to the surgery room from which the support persons were excluded. These support persons exhibited empathetic behaviours similar to those of the effective support persons present for normal births. The supported women felt the congruence in their support person's attitude, feelings, words, and behaviour and this congruence helped the women feel comfortable both before and after they were moved to the surgery room.

The midwives or the doctors had gained positive impressions of the support provided prior to the caesarean, and reported that all women were relaxed and were ready to have the caesarean. There was, however, an inconsistency in the data gathered regarding one woman's readiness (woman 30) for a caesarean birth. In that case, the woman and her support person did not share the doctor's judgment that the woman was ready for a caesarean birth and this discrepancy may perhaps reflect the doctor's greater experience and knowledge regarding caesarean birth.

Effective support was not provided by one emotionally ill-prepared support person (for woman 45). While this husband said that he would support his wife, his behaviour did not align with this intention as he was too sleepy to provide effective support. The midwives eventually asked this man to leave and sleep outside the room and they took on his role of providing support to the woman.

This woman thus received little support from her husband, perceived the incongruence between her husband's stated intention and his behaviour and felt uncomfortable. Her husband had not proved trustworthy in his role as a support person and she became flushed and uncomfortable. The midwives' observations confirmed this woman's discomfort, noting that her blood pressure increased to 151/90 before returning to normal after the caesarean.

Only one woman (woman 41) reported feeling comfortable in the surgery room. The other women (women 2, 24, 30, & 43) felt uncomfortable - they experienced physical disturbances, their hearts pounded, they found it hard to breathe or they vomited. While it is unclear whether the causes of these disturbances were physiological or psychological, most of these disturbances disappeared when the baby was born. It is likewise unclear how much being unexpectedly deprived of the presence of their support person and the expectation of an uncomplicated vaginal birth may have contributed to their discomfort.

Based on the findings of this study, it is clear that the support person plays a significant role in effectively supporting the women during labour and childbirth. However, this study highlighted that some designated support persons may not be able to provide effective support for reasons relating to their attitudes and behaviours or their lack of knowledge of the support that would be welcomed or effective.

The next sections discuss the perspectives specific to women, the support persons, and midwives.

5.4 Similarities and Matching Themes– Women and Support Persons

My observations and conversations with the women during this and my previous studies (Natalia, 1998, 2000, 2008) affirmed childbirth was a very special event for them, and their families - the much-anticipated culmination of nine months of pregnancy and for several, many years of hope. Their view of childbirth as a special event led the women and their families to expect that the midwives would treat childbirth as a special event and be very supportive of the childbearing women and their family. Parents with prior experience of childbirth practices at the maternity centre had more realistic expectations of midwife support than did first-time parents, who did not realise that managing childbirth was a routine rather than a special event for the midwives.

By contrast with the somewhat excessive and overly optimistic expectations of the support that midwives would provide to childbearing women and their families, neither the women nor their family members who volunteered to act as support persons for the birth seemed able to formulate a set of expectations for a childbearing women's support person. As this study, my previous studies (Natalia, 1998, 2000, 2008) and other Indonesian studies (Defiany et al., 2013; Magfuroh, 2012; Primasnia et al., 2013; Sektiawan, 2010; Stiarti, 2011) have documented, it is still not yet common in Indonesia for women to have a support person during labour and childbirth. It is, therefore, not surprising that fifteen (71%) of the 21 women and (52%) of their support persons in this study had no detailed expectations or imaginings about the support they expected a support person to provide during the labour and childbirth process. They simply hoped

that having a support person present would be worthwhile and make some positive contribution to the experience.

All the women participating in this study understood that the support person could stay with them in the birthing chamber but would not be permitted to accompany them to a surgical suite if a caesarean birth was required. This may not have been a major concern since all those women expected to have normal births, a somewhat unrealistic expectation given six of the 21 had unplanned caesarean births.

This finding of ‘no idea’ of the support person role contrasts with studies in other countries where women did articulate their expectation of support during childbirth in more detail (Gibbins & Thomson, 2001; Gibson, 2014; Iravani et al., 2015). Because the women in this study had no detailed expectations, it is not possible to explore the extent to which their detailed expectations of support during childbirth were fulfilled.

In this study, the first theme of the women was similar to the support persons’ answer, which was “I have no idea”. This similarity may be explained by understanding their culture, and how Javanese values and Javanese philosophies may have contributed to the women’s and support persons’ inability to give a detailed description of their expectations of support during labour and childbirth details.

As mentioned in the literature review, Indonesian women usually have no support person during labour and childbirth despite WHO (2018) and Kementrian Kesehatan Republik Indonesia (2013) recommendations. It seems possible that since women, particularly those who have had children and experience, were not allowed previously to

have support during labour and childbirth, they, therefore, did not expect that they might have opportunity to experience it during this labour and childbirth.

The families in this study lacked experience or knowledge about support during labour and childbirth, and so this left them unable to describe what kind of support they expected. Based on this possibility, information may be provided to the support persons to prepare themselves to support the women during labour and childbirth.

As discussed in Chapter 2, Javanese values taught people to practice *pasrah* in life, particularly if they face problems beyond their control (Endraswara, 2016, 2018). In this context, because only the midwives could help the women give birth, both the women and the support persons tended to be *pasrah* to the midwives.

Irrespective of the religion they practice, the Javanese value *ana sethithik dipangan sethithik* means when there is a little, a little should be eaten. This means that Javanese people are advised to accept anything in life that is “given by God” (Endraswara, 2016; Suseno, 1996) and thus prefer not to be or seem to be too ambitious. It seems possible that in accordance with this Javanese value, both the women and their support persons tended not to formulate detailed expectations, or resisted sharing any they had formulated. Any detailed expectations could be seen as too ambitious according to Javanese values.

Irrespective of the religion they practice, Javanese people believe that “God has planned” (*siji pati, loro jodho* and *telu tibaning wahyu*, which means first rice, second soul mate, third wealth). This means that God has administered food, a soul mate, and

wealth to people. Because of that, Javanese people tend to trust God and do not have highly detailed expectations (Endraswara, 2016; Suseno, 1996). This value might have influenced the women and support persons in this study in that they tended to have no expectations because they believed that everything has been planned by God, including the process of childbirth.

It seems possible that these findings are due to the Javanese value that people are advised to avoid expectations, particularly when they face important moments in life, such as marriage, pregnancy, childbirth, and gender of the unborn baby, but to accept that these reflect God's will (Endraswara, 2016; Untari & Mayasari, 2015). In this study, the women also believed that to select a baby's clothes and equipment based on gender (such as blue for a boy and pink for a girl) seemed "taboo" until after seven months of pregnancy (*Tingkeban* ceremony). Delaying preparation of clothing and equipment until a couple of months before the expected birth date showed an acceptance of God's will.

According to Suseno (1996), Javanese people are also taught to speak calmly and "not express their emotions" openly. Javanese people have been brought up in this way, and this may be the reason why the women and support persons tended not to be able to describe their expectations about support during labour and childbirth: it is "not" common to "express wishes openly" (Suseno, 1996).

Another possible explanation for the lack of expectations about support is that the social hierarchy applying in Indonesia, particularly in Javanese culture, including in the healthcare area, meant women and support persons sensed that they were only *tiyang alit*

(unworthy people) (Endraswara, 2016; Suseno, 1996) compared to the doctors and midwives. According to Suryadi et al. (2014) the Javanese community assign stratified-levels as an important part of their life. Most women and the support persons attending the maternity centre where this study was conducted came from a middle to low socio-economic level background. As “*tiyang alit*”, they respected and obeyed people from a higher socio-economic level and were thus prepared to accept whatever service provided to them. Satoto’s work (2004) in Central Java and the participants in this study would trust the midwives’ advice and would not query this advice because of their belief that the midwives are the experts and have much more knowledge. The prevailing view expressed by the women and their support persons was that the support person would be a passive presence during labour, while the midwives would be directing and managing the labour process as reflected in the second sub-theme “I trust the midwives”.

The participants in this study were prepared to break with accepted practice by having a support person present for labour and childbirth. When I offered the possibility to have a support person during labour and childbirth, all the participants were interested in participating in this study. The expectations that were articulated were nevertheless very simple. The women expected “Just support me” and the support person expected “(I plan to) fully support (her)”. The women focussed on the support person’s *intention* rather than behaviour. This again may reflect the Javanese values of *pasrah* and *ana sethithik dipangan sethithik* (Endraswara, 2016). Having already practiced *pasrah* in their daily life for years, they routinely apply *pasrah* when confronting experiences, beyond

their control including labour and childbirth. In accordance with *ana sethithik dipangan sethithik*, they aim not to be too ambitious in life and accept whatever God gives to them (Endraswara, 2016; Suseno, 1996). Another possible explanation is that Javanese value as *tiyang alit*, they were aware of their position in their community (Endraswara, 2016; Satoto, 2004; Suryadi et al., 2014; Suseno, 1996). Because of that, Javanese people often have no high or detailed expectations about dealing with something. They only have simple expectations, with no further explanation.

In alignment with Chapman's explanation (1995), the women in this study expected that the support persons just be there, providing quality time, being focused on the women and paying attention to their needs. Attention to the women reflected the support person's intention (May, 1965), while intention consisted of meaning and movement towards something meaningful (Figure 16). In other words, when the support person pays attention to the women's needs, it means that the women are meaningful to the support person, and are being loved. As Chapman (1995) stated, being there only for the women, the support persons would be recognized as loved ones who love the women. This is a powerful emotional communication of love (Chapman, 1995). By being loved, the women would feel secure and relaxed during labour and childbirth. The women in this study also expected that the support persons would be ready if they needed or wanted something. This women's expectation seemed to confirm Chapman's explanation (1995) that the acts of service of the support persons would reflect that the women are loved and the support persons are unselfish because they would put the needs of the women first.

Women expected that their husbands would acquire valuable knowledge by being present during labour and childbirth. A key theme of the women's expectations of the benefits of having a support person present was that it would "Provide husbands with experience of the childbirth process". As previous studies show, individuals tend to spend their valuable limited opportunity or time with those who are closest to them, such as their spouse and their family (Naftali et al., 2017; Natalia & Pramadi, 2007). The women in this study wanted to share the peak experience of childbirth with the person closest to them, their husband. Because childbirth is a family moment, they expected to be experienced with their loved spouse. In addition, the women were convinced that being with them in labour and witnessing the birth would provide their support person with insights into the childbirth process. The women expected that the husbands would love, value and respect them more having witnessed their life and death struggle to bear their baby.

Reluctance to witness the painful birth process (*tidak tega*, don't want to see her in pain; I don't want to see her suffer) was, however, a key theme for the support persons. They felt *tidak tega* to see the women in pain if they could not help to relieve their pain, clearly not understanding that emotional support can reduce anxiety and pain. A mother who considered being a support person even said that it would be better if she herself underwent labour and childbirth rather than seeing her daughter in pain and being unable to do anything to relieve her suffering. It seemed that the support persons did not share the women's convictions that husbands acting as support persons would acquire valuable

knowledge or share a peak experience, or love, value and respect their wives more having witnessed the struggle to give birth.

Reluctance to witness the painful birth process was not sufficient to prevent the husbands or mothers in the study from volunteering to undertake the role of support person. This may be explained by the support person's empathy for the woman they wanted to support. A recent study has shown that observing others suffering pain can stimulate activity in affective areas in the brain that are associated with empathy (Singer et al., 2004). The study found that the same brain areas, bilateral anterior insula (AI) and rostral anterior cingulate cortex (CC), were activated when the participants received pain and when they observed their love one received pain (Singer et al., 2004). The activation has correlation with the participants' empathy score (Singer et al., 2004).

5.5 Research Question 1 – Perspectives Specific to the Women

My study found similar results to previous studies within (Astutik & Sutriyani, 2017; Baker, 2010; Defiany et al., 2013; Diponegoro & Hastuti, 2009; Kartini, 2011; Lailia & Nisa, 2015; Primasnia et al., 2013; Sari, 2010) and beyond Indonesia (Baker, 2010; Dlugosz, 2013; Klaus et al., 1986; Reynolds, 1988; Torres, 2015) that support during labour and childbirth led to a positive experience for the women and support persons. The majority of the women in this study were comforted by having a support person accompany them during labour and childbirth. This finding aligned with the

findings of other studies conducted in Indonesia by Diponegoro and Hastuti (2009) and Johariyah et al. (2014), where women were free to choose different support persons.

All but two of the women in my study felt effectively supported by the support person accompanying them during labour and childbirth. One of those women had a normal birth, while the other experienced an unplanned caesarean childbirth.

5.5.1 Choosing a support person

In this study, the pregnant women had freedom to choose their husband or mother or some other volunteer as a support companion. By contrast, some previous studies (Baker, 2010) either only involved husbands (Dlugosz, 2013; Kartini, 2011; Lailia & Nisa, 2015; Primasnia et al., 2013); or doula companions (Klaus et al., 1986; Torres, 2015), or it was not clear whether the women were allowed to choose a husband or another relative or friend or doula as their support person (Astutik & Sutriyani, 2017; Defiany et al., 2013; Reynolds, 1988).

While childbirth might traditionally have been viewed as women's business, all 21 women in this study requested their husband rather than their mother as a support person, though three women had their mother as support person. This was because the husband declined. This finding is similar to a study which was conducted in Nigeria by Morhason-Bello et al. (2008) which found that 86% of women preferred to be accompanied by their spouse as their birth companion. Except for one husband who is a

healthcare staff member at the hospital, none of these husbands had previously witnessed their wives giving birth in a maternity centre.

Female relatives were clearly a second preference and were only recruited as support persons in a few cases when it was impossible for the husband to act as a support person. Female relatives' experience and expertise in childbirth was clearly seen as a less valuable form of support than the presence of a husband. The possible reasons might be:

- The women wanted to provide their husbands with experience of childbirth so they would understand how hard the women struggle with the childbirth experience.
- Because this is a family moment, the women preferred to include their husband in this experience as a family member.
- Other family members might not be able to understand the women as their husband did, or would be more talkative. The midwives shared that some mothers got angry with their daughters when they accompanied them during labour and childbirth.

Only where the husband was unwilling to act as the support person did the women choose to be supported by their mothers.

It is important to consider husbands as an Indonesian woman's most preferred support person, both because the women wanted to "provide my husband with experience of the childbirth process" and given there are several previous studies that confirm the presence of the husband during labour and childbirth can strengthen the bonding of the women, husband, and baby (Dlugosz, 2013; Wasthu, Yunani, & Yustina, 2015).

No women in this study proposed their mother-in-law or any female relative other than their own mother as a support person. Some women indicated their own mother was their second preference for a support person, which possibly reflects a close bond between mothers and daughters and the daughters' acknowledging the relevance of their mother's experience and expertise in childbirth, even though that expertise and experience may have related to quite a different birthing situation. In Morhason-Bello et al.'s 2008 Nigerian study, the number of women who wanted to be accompanied by their mother or siblings during labour was likewise low, being 7% and 5% respectively.

In this study, four husbands declined to act as support person even though their wives had invited them to accompany them intrapartum. The reasons provided by these husbands for their hesitation to accompany their wife during labour and childbirth were similar to reasons reported in previous studies (Longworth et al., 2011; Poh et al., 2014). As in these studies, which were conducted in England and Singapore, some husbands felt confused with their new roles. They needed information and support from the health care staff in order to provide better support for their wives during labour and childbirth. Even though they attended antenatal classes with their partner, some of them still needed more information about the importance of their role in order to have a good perception of their role and be responsible to their role by accompanying their wife during labour and childbirth. Where the husbands in my study declined to take on the support person role, the women's mothers volunteered to take their place. In one case where the woman's

mother also declined to take on the support person role, the husband eventually reluctantly volunteered for the support person role.

The midwives acknowledged the importance of informing the women and their support persons about the importance of providing support during labour and childbirth, the means of providing this support, and to manage anxiety about labour and childbirth. While previous studies (Longworth et al., 2011; Poh et al., 2014) mentioned the value of preparation class for the fathers, antenatal classes of any kind sadly remain rare in Indonesian maternity centres and antenatal classes addressing both the physiological and psychological aspects of the birthing process are not available. My discussion with the midwives revealed, however, that the information provided to pregnant woman and anyone accompanying them to their antenatal classes was purely physiological and did not explore any psychological aspects.

Midwives reported that in their experience most of their antenatal class participants are women and very few of them come with their spouse. It should be noted that children and female relatives but not husbands are permitted to accompany pregnant women to the optional pay-to-attend gymnastic classes offered at the maternity centre.

There were several possible explanations for this. Cultural differences mean Indonesian men with pregnant wives might perceive such classes as less necessary, less valuable and less appealing than alternative uses of their time than the men studied by Longworth et al., (2011) and Poh et al., (2014). It is very likely that cost considerations and work commitments would prevent many Indonesian husbands from accompanying

their wives to antenatal classes during business hours. The husbands may not moreover be living or working in Surabaya. Other barriers could be the husbands' belief that they cannot provide any significant contribution in the labour and childbirth process and should simply trust the midwives to manage the process. It is unclear whether the support persons in this study had attended any antenatal classes.

As the cognitive psychology approach holds that an individual's perception is influenced by prior knowledge, attendance at antenatal classes has the potential to overcome anxieties and support persons' negative perceptions by providing positive knowledge about labour and childbirth. Better knowledge of the process of labour and access to pictures or films about these processes and the support person's role in the childbirth room, the possible supports they could provide, and how to cope with their own anxiety about women's labour and childbirth might encourage and equip more people to volunteer to serve as support persons accompanying women during labour and childbirth.

Providing such information gradually over time to potential support persons can nurture positive perceptions about labour and childbirth, help overcome anxieties and enhance their capacity to act as effective support persons. Information provided to prospective fathers in other countries via antenatal preparation classes could be made available in Indonesia via flyers, TV advertisements and programs, and radio.

Despite lacking access to any preparation classes, only one of the support persons in this study proved unable to provide effective support.

5.5.2 Before - Women's perceptions about support during labour and childbirth

5.5.2.1 Indications of underlying anxiety

Much of the participant women's data collected for this study revealed some underlying anxiety as reflected in a key sub-theme: "I've avoided thinking about it". This anxiety was reflected in woman 13's response, "I don't want to think about it ..."
(laughing while shielding her face with both her hands). As a narrative inquiry researcher, I needed to observe and analyse this gesture, her twin behaviours of laughing and closing her face to gaze appear to reflect a contradiction between a positive emotion (laughter) and a negative emotion (fear shown by shielding her face).

As Blot (1992) noted, understanding Indonesian culture is needed to understand its people's behaviour. This woman's twin behaviours could be understood in terms of Javanese culture, where efforts to maintain harmony can result in people behaving in ways that appear to conflict with their original purpose (Endraswara, 2016; Prawitasari, 1995; Suseno, 1996). To maintain harmony within herself by laughing, Woman 13 was using a typical Javanese coping style.

As discussed in Chapter 2, anxiety regardless of its practical cause is the struggle of the living being against nonbeing (May, 1969). The anxiety women felt about giving birth may, therefore, have been related to their perception that it can bring them closer to death (Batbual, 2014; Handelzalts et al., 2015; Johariyah et al., 2014; Kasdu, 2007; Lowe, 2000; Matinnia et al., 2015; Rahmy, 2013; Ryding et al., 2015; Schetter & Tanner, 2012). The women in this study may thus have avoided thinking about support during

labour and childbirth to distance themselves from the unpredictable process of labour and childbirth and its attendant risk of death.

5.5.3 During - Women's perceptions about support during labour and childbirth

In this study, the presence of the husbands/mothers during labour and childbirth contributed positively to the birthing women's well-being. As mentioned earlier in this chapter, the husbands/mothers helped the women by a range of empathetic behaviours including listening to their sharing of feelings. These behaviours helped the women to feel understood, supported, secure, and safe and this stimulation of positive emotion is associated with a decreased perception of pain (Goldstein & Brockmole, 2017; Ogden, 2007). In the absence of these behaviours women felt less supported and suffered greater stress.

5.5.3.1 Women's theme 1: I was pleased with the support (having the support person present was positive)

As mentioned earlier, the women in this study reported the presence of a known and trusted support person helped them to relax though initially these women had no expectation regarded the benefits the presence of a support person might deliver. Their participation in this study does, however, suggest that they may have hoped for some benefits even if they did not explicitly formulate those expectations. Because the women initially had minimal or no expectations and had prepared themselves to accept whatever

they received, they felt particularly pleased and satisfied when they received more than they expected.

As mentioned in the literature review, Javanese values significantly influence Javanese people including the women in this study. Those Javanese values encourage people to be *nrimo*, *pasrah*, *sabar*, hoping *sethithik*, and aware of themselves (particularly as *tiyang alit*) (Endraswara, 2016; Sadli, 1984; Suryadi et al., 2014; Suseno, 1996).

These Javanese wisdoms seemed to be a typical Javanese coping style. It might be a protection from disappointment and failure and this approach also accords with other spiritual traditions such as Buddhism. As Buscaglia (1972) said:

The Buddhist says that you are well on your way to enlightenment when you “cease desiring.” Perhaps we can never reach this enviable state of peace, but to the extent to which we can live without demanding or expecting (except from ourselves), so can we be free from disillusionment and disappointment. (p. 67)

5.5.3.2 Women’s theme 2: It gave me companionship

The second theme of the women’s experience about support during labour and childbirth reflects the findings reported in the previous studies (Dlugosz, 2013; Lailia & Nisa, 2015). A study conducted in Australia (Dlugosz, 2013) found that the presence of their husband made women feel safe and protected. The women seemingly benefitted from having their husband beside them during labour and childbirth, to fulfill their

psychological needs rather than physical needs, although the effect was beneficial to the physiological process. This may be aligned to findings of Bingel et al.'s study (2011) that even the presence of a support person doing nothing may promote positive emotions in the supported woman.

According to Buscaglia (1972), humans are essentially social beings and need other people to grow. The need for deep relationships is reflected in a marriage (Buscaglia, 1972). Buscaglia stated that humans need love. The women in this study also expected to be loved by their support person, who might be the only one who cares deeply or the one who cares most deeply for them.

According to health psychology (Ogden, 2007; Sarafino & Smith, 2011) and cognitive psychology (Goldstein & Brockmole, 2017) approaches, positive emotions can be associated with decreasing pain perception. Having their support person with them stimulated positive emotions, enabling the women to relax and reducing their perceived pain.

5.5.3.3 Women's theme 3: It was freeing

The third theme of the women's experience of support during labour and childbirth was 'It was freeing', specifically 'My support person helped me to be free'. This theme links to the third theme of the support persons' experience of supporting women: 'I took action to try and end her pain and suffering'.

Being ourselves has been described as the easiest and most rewarding thing to do in this world (Buscaglia, 1972). If our 'inner world' is consistent with our external expression of it and no barriers inhibit the process of expressing our 'inner world' to the outside, then we need less energy to express our 'inner world'.

This is similar to the concept of congruence proposed by Rogers (2004) where congruence indicates an accurate matching of experience, awareness, and communications. Rogers (2004) held that being 'contained' never helps individuals to grow.

Before labour and childbirth, the women might not be able to express themselves if they adhered to Javanese values opposing open expression of themselves or even explicit statements of their expectations. While they experience labour and childbirth, with support from a known and trusted person, they did feel free to be themselves at least within the relative privacy of the birthing chamber. The situation might have been different had they been accompanied by a person other than their chosen 'known' and 'trusted' support person. The choice of support person during labour and childbirth, therefore, played a key role enabling this freedom of expression.

According to Buscaglia (1972), humans have physical and psychological needs. The unconditional acceptance of the women's need to manage their birth experience in the way they instinctively needed showed the women that they were loved.

5.5.3.4 Women's theme 4: It was annoying

The fourth theme of the women's experience about support during labour and childbirth was 'It was annoying', and this acknowledged that having a loved one with them intrapartum was no guarantee of effective support. Interestingly, only one woman felt she was 'not understood' or not optimally supported by her designated support person.

The data in this theme demonstrate that this woman felt misunderstood by her husband. She was upset by the contradiction between the husband's actual behaviour and his *intention* about how he expected he would behave during labour (that is, to support the women). The annoyed woman's experience was that the husband did not "turn his mind towards" the woman, but remained focused on himself or the midwives. It meant that the woman who experienced this had no "meaning" to her husband. This awareness that the woman was not meaningful to the husband made the woman feel disappointed.

The woman felt annoyed because the husband's statement of his intended behaviour and his actual behaviour were incongruent. According to Rogers (2004), congruence is one of the general laws of interpersonal relationships. On the basis of the husband's incongruency, the woman might feel that her husband was not trustworthy. However, she needed support from her husband. Because she did not have his support, she felt uncomfortable during labour and childbirth. The midwives found that the woman felt uncomfortable.

5.5.4 After - Women's perception of support during labour and childbirth

Women who had the support of a trusted family member in labour, and continued to experience their support in the postnatal period, felt meaningful, loved and enjoyed unconditionally positive regard.

5.5.4.1 Women's theme 1: Being supported

The theme in the women's experience of being supported aligns with previous studies endorsing support during labour (Bohren et al., 2017; WHO, 2015, 2016, 2017) because of its capacity to increase women's childbirth satisfaction. As discussed earlier, Javanese values may have influenced the satisfaction reported by the participants of this study.

5.5.4.2 Women's theme 2: Just let husband know the childbirth process

The second theme of the women's experience about support during labour and childbirth was 'Just let husband know the childbirth process'. When asked about their reasons for choosing their husband to accompany them in labour, several women in this study stated that they wanted to let their husbands witness the childbirth process. They expected that their husbands would understand and appreciate the birth experience more if they observed it directly, and that in turn this would, as Rogers (2004) suggests, diminish any barriers between them as a couple.

5.6 Research Question 2 – Perspectives specific to Support Persons

5.6.1 Before- Support persons' expectation about support during labour and childbirth

5.6.1.1 Support persons' theme 1: I have no idea

Thirteen (62 %) of the support persons were unable to describe how they might effectively support a birthing woman, because as stated in the sub-theme “(Because) I never expected I would be there”. Rather than relying totally on the midwives for relevant information, some of the support persons did seek information from the articles, website, YouTube videos or asked other friends or family members about their experiences. None of the support persons mentioned asking the woman they were preparing to support for advice about what actions might be helpful, perhaps because those support persons thought they already knew that woman's preferences in other contexts or because they thought the woman herself might have no idea of which actions might help her during labour and childbirth.

This finding is in contrast to the previous study in the UK (Longworth et al., 2011) in which the husbands could describe their expectations during labour and childbirth. The possible reason may be because of the cultural differences between the two study populations: people tended to be able to describe their expectations in the UK while in Indonesia, specifically Java, people tend to not express their expectation or emotions openly. As described in the previous section, Javanese people tend to trust God and do not have highly detailed expectations (Endraswara, 2016; Suseno, 1996).

5.6.1.2 Support persons' theme 3: *I tidak tega; don't want to see her in pain; I don't want to see her suffer*

Although women wanted their support person to witness the reality of childbearing, support persons were wary of doing so. The third theme in the support persons' data - "*I tidak tega; I don't want to see her in pain; I don't want to see her suffer*". The Indonesian term "*tega*" refers to both the speaker's *compassion* and *fortitude*. Many of the support persons expressed *tidak tega* when they imagined accompanying the women during labour and childbirth. They feared witnessing the pain would exhaust their reserves of compassion and fortitude. Mothers who had agreed to act as their daughter's support person even said they would rather give birth themselves than see their daughter do so.

This unwillingness to witness pain perhaps reveals an underlying anxiety that the support persons would not be able to cope with witnessing pain in the women, and would not be able to provide any form of support that could effectively help to minimise or alleviate the pain. Goldstein and Brockmole's (2017) review of recent research on pain perception theory concluded that seeing others suffering pain can stimulate activities in the affective area in the brain, and this provides a theoretical basis for the support person's concerns.

As May (1977) argued, anxiety also has a positive meaning and can prompt acceptance of new learnings and a willingness to adjust previous plans. In this study, the positive meaning of this support persons' anxiety is discussed in more detail in the

section dealing with the support persons' experiences of being present during labour and childbirth.

5.6.2 During - Support persons' perception about support during labour and childbirth

Despite their desires to avoid witnessing the women fighting pain and fears of not being able to do anything to help reduce the pain, most of the support persons in this study had a positive perception of their support during labour and childbirth. As shown in Figure 38, the three themes that emerged from the support persons' experiences about support during labour and childbirth were:

- I have a new appreciation for what it takes to give birth,
- I gave my full support,
- I took action to positively end her pain and suffering.

Each of the themes is discussed below.

5.6.2.1 Support persons' theme 1: I have a new appreciation for what it takes to give birth

The first theme of the support persons' experience about support during labour and childbirth was 'I have a new appreciation for what it takes to give birth'. Unlike the support persons who were themselves mothers, the husbands witnessing the childbirth experience for the first time understandably felt anxious and unprepared and had

underestimated the impact this experience would have on them and their understanding of what the birth process involves.

The husbands' anxiety about watching the women struggle with pain and acknowledging the risk of death during labour and childbirth had a positive aspect. As May (1977) stated, "Anxiety has a meaning" (page xiv) and may be the best teacher. In this study the constructive outcome of the support persons' anxiety was evident after labour and childbirth. For example, two changed their plans regarding the number of children they wanted to have. Before commencing their support person role, two husbands had planned to have many children, but after completing their support person role, they were in agreement with their wives' preferences for fewer children and prepared to accept whatever she decided, even if that meant they would be a one-child family.

The husband's anxiety was an enlightenment to them. It changed their point of view and decisions they had made. A good example of this was husband 7. At the beginning he planned to have many children. However, after seeing how hard his wife struggled to bear their baby, he had a new enlightenment that made him see the world differently. He changed his decision about the number of children that he would have that was totally different to his previous decision.

5.6.2.2 Support persons' theme 2: I gave my full support

Accepting the invitation to serve as a support person demonstrated an “intention” to accompany the women. In an article by May (1965) titled “Intentionality, the heart of human will” stated that intention refers to “meaning” and “toward to”. He said that it included human “awareness”. Most of the support persons considered the woman they accompanied as precious and meaningful to them. The women were aware that they were also meaningful to the support person.

In the childbirth room, most support persons showed their unconditional positive regard (Rogers, 2004) by supporting the women to the best of their ability, providing their fullest support. The support persons did whatever was necessary to help the woman get through labour, even “sacrificing” themselves when the woman harmed them in the process. Some of the husbands effectively supported the wives through their difficult time by making no complaints and remaining silent when the women grabbed them, squeezed their lips, pulled their hair or pulled and tore their clothing. They were allowing the women to manage pain by expressing themselves more freely than would be accepted in other circumstances. Others took more active support measures such as praying or providing support through touch, talk or advocacy. This acceptance made the women feel free as reflected in the theme “My support person helped me to be free”.

The support persons “understood” the women and accepted whatever they did during labour and thus provided unconditional positive regard to them as Rogers (1980) said that unconditional positive regard made individuals, in this study, the women, feel

accepted and loved unconditionally. The experience of the women in this study is reflected in Yalom's (2002) assertion that "acceptance and support from one who knows you so intimately is enormously affirming" (p. 14).

Awareness that one is loved, accepted, valuable, and meaningful to others enhances self-esteem, which in turn increases the self-confidence about overcoming obstacles encountered in life even in – or especially in - the moments as challenging as childbirth. It could be theorised that the support persons' acceptance of women's requests and behaviours in labour made the women feel that they were loved, valuable, and meaningful to the support persons. Being part of a special and meaningful experience may have made the support person feel valued and meaningful.

The support that women received made them believe in their ability to give birth. The encouragement the women received from their support person may have enhanced the women's self-efficacy, which in turn facilitated their labour and childbirth. As noted earlier, the encouragement and support provide to the birthing women included verbal and non-verbal components.

5.6.2.3 Support persons' theme 3: I took action to try and end her pain and suffering

The third theme about the support persons' experience is 'I took action to try and end her pain and suffering'. This clearly conveys both that support persons had some insight into the pain suffered by the women and that they were pleased and proud of the actions they were able to undertake as part of their support role.

Despite their earlier expressed anxieties, the support persons were not mere passive witnesses to the birth process. They demonstrated their empathy for the birthing women by their encouraging them to do whatever they felt they needed to do to manage their pain. They also translated midwives remarks about the birth progress into encouraging messages. According to Sarafino and Smith (2011) this action is an instrumental aspect of support.

The support role also included advocating for the women. These efforts were a source of satisfaction even if they were unsuccessful. One husband was pleased to have advocated for his wife to have a caesarean birth to put an end to her pain. His advocacy efforts had, however, overlooked the clinic's accepted practice of only performing caesareans in cases of medical necessity and the midwives advised him that it was already too late to do a caesarean in that case.

The range of activities that the support persons performed did not include sharing music via mobile phones or other devices and could perhaps be broadened to include this possibility.

5.6.3 After - Support person's perceptions about support during labour and childbirth

5.6.3.1 Support persons' theme 1: Fully support

Most support persons were pleased that they had tried to provide their fullest support when they accompanied the woman during labour and childbirth. They felt

grateful that they could accompany the woman during labour and childbirth. As discussed earlier, it was their commitment that determined the effectiveness of their support.

This finding is similar to the previous study in that the support persons provided full support to the women (Astutik & Sutriyani, 2017; Defiany et al., 2013; Diponegoro & Hastuti, 2009; Johariyah et al., 2014; Kartini, 2011; Lailia & Nisa, 2015; Primasnia et al., 2013).

5.7 Research Question 3 – Perspectives specific to Midwives

5.7.1 During – Midwives’ perceptions about support during labour and childbirth

Having interacted with midwives when collecting data in my previous studies (Natalia, 1998, 2000, 2008), I understood that from the midwives’ perspective, childbirth was a routine experience rather than a special event. In a typical working day, a midwife would deal with three to five instances of childbirth. During a single shift, a midwife might be attending to several birthing mothers within the birth room.

Despite the practice of midwives routinely excluding people other than health professionals from the birthing chamber, all the midwives in this study had positive responses regarding the support provided during labour and childbirth. Having allowed some women on the hospital’s staff and other women they knew well to have a support person present during labour and childbirth prior to this study, they already had some understanding of the support person’s role.

Despite concerns that the support person might panic or cause problems, midwives reported that the support persons helped them to reduce the women's anxiety during the labour and childbirth. No midwives regarded the presence of the support person as a threat to the privacy of persons in the other birthing chamber.

It may be that the midwives participating in this study were more open-minded and interested in innovation than some or even many of their peers. The midwives in this study were younger than those in my previous studies and some already knew that the presence of a support person during childbirth and labour was considered beneficial and has become accepted practice in many countries and in some of Indonesia's private hospitals. These midwives thought midwives at other hospitals and birthing centres may be less patient-focused and more resistant to having support persons present during childbirth.

The midwives' perspectives about lay person support during labour and childbirth has not been reported. Many studies have reported support during labour and childbirth based on the women and support persons' perspectives, however, the midwives' perspective is unique to the current study.

5.7.1.1.1 Midwives' theme 1: The support person helped me to support the woman

While the midwives' prevailing view was that the midwives would lead the process, they acknowledged 'The support person helped me to support the woman'. They too saw the support person as a valued and active participant in the birth process rather

than a mere passive witness to it. The presence of a ‘known’ and ‘trusted’ person who engaged in talking, engaging in prayer, consoling, stroking, holding hands, massaging, feeding, serving, helping the woman to find a comfortable position, guiding the women to take a breath, calling the midwives, discussing the women’s condition with the midwives during labour and childbirth helped the midwives to do their work more easily.

5.8 Implications for improving childbirth experiences and outcomes

Trust is a very important consideration for women experiencing labour and childbirth and interacting with midwives and their support person. While trust should ideally exist between the women and their midwives and indeed between all parties, the provision of effective support requires trust between the birthing woman and her designated support person. The effectiveness of support during labour and childbirth depended on the nature and quality of the human relationship between the woman and her designated support person. This accords with the work of Rogers (2004) discussed in Chapter 2 and his emphasis on the importance of congruence, trustworthiness, genuineness in human helping relationships.

While this study found that the women, the support persons, and the midwives had generally positive experiences about support during labour and childbirth, there were cases where more effective support could have been provided. As Bugelski and Alampay (1961) found in their study, prior knowledge influences perception. Better knowledge about labour and childbirth and the action that a support person can take to assist the

birthing woman and the birthing process can change perception and enable the provision of more effective support. As the cognitive psychology approach highlights, individuals' perceptions are influenced by their prior knowledge (Goldstein & Brockmole, 2017) and a lack of relevant knowledge can influence feelings, producing a sense of being emotionally unprepared. Providing support persons with the "necessary" information could thus change their perceptions and enable them to become emotionally prepared and more effective in providing support.

Studies in Indonesia (Amilda, 2010; Anggorodi, 2009; Maas, 2004; Nuraeni & Purnamawati, 2012) show some women prefer support from *dukun bayi*, perhaps because *dukun bayi* provide support from pregnancy until after birth, including participation in traditional ceremonies (Appendix B). This finding is similar to those of a study conducted in Australia, in that the women also felt comfortable having emotional support after giving birth (Fenwick et al., 2013). Overall, research has found that the women still need support even after giving birth. In addition, the cost of employing a *dukun bayi* is highly affordable.

5.9 Summary

This study considers the findings of the current study in relation to previous work and theory relevant to the subject of lay support during labour and birth. It also provides further evidence of the benefits of having a support person present during labour and childbirth. The birthing women's perception of their support persons' trustworthiness

depended on the extent to which their support persons' attitudes, feelings, words, and behaviours were aligned and consistent. Where the support persons' attitudes, feelings, words, and behaviours were aligned and genuine, they were perceived as trustworthy by the birthing women and proved capable of effectively providing support to the birthing women. Most support persons, and all the midwives had positive experiences about having a support person present during labour and childbirth.

In Rogers' (2004) terms, the effective support persons in this study accepted and understood the persons they were supporting and showed their understanding of the women's feelings, thus giving the women freedom to be themselves. The support persons' perceptions about providing support in labour and childbirth were influenced by their commitment to the role and the knowledge they had. A lack of relevant knowledge leaves them less emotionally prepared for their role. The effectiveness of support provided during labour and childbirth could be increased by provision of ready access to relevant information.

The next chapter provides conclusions and recommendations.

CHAPTER 6: CONCLUSIONS

6.1 Introduction

In general, this study found that the women, support persons, midwives and doctors had positive experiences and views about the provision of support by designated support persons during labour and childbirth. The effectiveness of the support provided to the woman during labour and childbirth depended on the strength of the human relationships between her and her designated support person. The support person reported their satisfaction with their role depended on their perception of being an active participant in the process of bringing a new life into being, being part of a unique event of special significance to their families, being able act to help relieve the pain and suffering of the women they were supporting and being able to complement the work of the midwives. The midwives likewise perceived the presence and efforts of the support persons as complementary to their own work, beneficial to the health and wellbeing of the birthing women and an aid to the birthing process.

6.2 Significance and Potential Impact

This study contributes new knowledge to the discipline of midwifery, in particular, about the psychological aspects of midwifery, and to maternal, child and family health because the study:

1. applied a biopsychosocial model taking account of Indonesian, particularly Javanese culture, to address its research questions;
2. uses a humanistic approach to investigate how having a designated support person impacted on the women's expectations, experiences and assessment of labour and childbirth, something not addressed in similar studies in Indonesia;
3. also uses this approach to investigate designated support persons' expectations, experiences and assessment of the effectiveness and significance of their roles in the birthing process, something not addressed in similar studies in Indonesia;
4. investigates midwives' perceptions about the value of having designated support persons present during labour and childbirth, something not addressed in similar studies in Indonesia or other countries;
5. uses its exploration of these perspectives to gain a more holistic understanding about support during labour and childbirth, taking account of the differing perspectives of the women, support persons,

and midwives, something not addressed in similar studies in Indonesia or other countries; and,

6. makes a series of recommendations to ensure that the benefits of having a support person present during labour and childbirth can be maximised without incurring significant costs.

6.3 Recommendations

Despite the limitations acknowledged above, this study provides a basis for some recommendations with potential impact within and beyond Indonesia and the disciplines of psychology and midwifery.

As the presence of a chosen support person during childbirth and labour constitutes an inexpensive means of improving maternal and child health, this study recommends:

1. Promoting the importance of support during labour and childbirth to Indonesian (Javanese) women and health professionals in Indonesia, particularly Javanese culture, and other countries with similar cultures or maternity practices to increase their awareness of the roles that maternity centres, husbands and families can play in supporting women during labour and childbirth.
2. Providing information about the importance of support during labour and childbirth via posters at local health care centres.

3. Encouraging maternity centres to allow a wider choice of volunteer support persons such as nursing, midwifery, or psychology students.
4. Encouraging maternity centres to develop co-operative relationships with any *dukun bayi* support to the birthing women.
5. Providing training to the potential support persons to ensure adequate support for the women in labour and childbirth. This training should address the potential for Caesarean births and how this can impact the support person's role.
6. Ensuring the support persons chosen by the birthing women are permitted to enter the childbirth room to accompany and support the women during labour and childbirth.
7. Offering training classes and materials to the potential support persons to provide support, information, and guidance on how they can best support women during labour and childbirth.
8. Scheduling the training classes for support persons at times when most of the support persons will be able to attend, such as when support persons are waiting for women having routine check-ups or doing gymnastic classes.
9. Conducting further studies to investigate the impact that the provision of support during labour and childbirth has had on the lives and families of those involved.
10. Working with the Indonesian Ministry of Health to use newspapers, television, radio and social media to inform all Indonesians about the importance of support

during labour and childbirth via programs, community service announcements, and advertisements.

6.4 Limitations of the Study

Inevitably, this study has some limitations. Firstly, some potential participants had to be excluded from this study because they had difficulties attending their scheduled interviews. Priority was given to the scheduled post-natal interviews with women, their midwives and their chosen support persons rather than to pre-natal interviews with women and their chosen support persons. Because the missed pre-natal interviews could not be rescheduled, those potential participants had to be excluded.

Despite the intention to conduct all interviews in a similar setting, some support persons could not attend interviews at the maternity centre and so were interviewed in their own homes. While the relationship between the researcher and the interviewees appears to have been more important to the quality of the data collected than the interview setting, this variation in interview settings may have led participants to contextualise their information differently.

One other limitation is the reluctance or difficulty the participants had in discussing their wishes for cultural reasons. It challenged the candidate insofar as it was extremely difficult to obtain in depth data. Javanese people tend to 'hide' their views and feelings to maintain harmony or to be polite to other people. Qualitative research requires the participant's perspective, however, which this cultural consideration makes difficult

to obtain. Good qualitative research practice involves the researcher using open-ended questions to avoid leading the answers, however, in the Javanese context participants usually gave indirect/covert answers to these. Nonetheless, the stories the participants told are those they wished to tell, in the way they wished to tell them and to the depth they felt comfortable with.

Notwithstanding these limitations, the study reported in this thesis has answered the research question and helps to address the prior gap in knowledge about the nature, value and challenges to the implementation of lay support in labour for childbearing women in Surabaya, Indonesia.

The findings of this study have important implications for the care of childbearing women, those they wish to support them in labour, and midwives in Indonesia and for other countries that have similar maternity care systems. The impact of positive lay support must be recognised and actioned for the benefit of all concerned.

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APPENDICES

Appendix A – Indonesia – Family

Family plays an important role for Indonesian people. The importance of relationship among family to Indonesian people is reflected in a Javanese proverb “*mangan ora mangan asal kumpul*” that means eating or not eating, the most important is being together. The importance placed on family relationship among Indonesian people is clearly evident in the *mudik nasional* (national returned to home village) moment, the largest temporary human migration in Indonesia, during *Lebaran* (*Eid Al-Fitr*) every year (English First Blog, 2016). In 2018, some 19.5 million people, an increase of 15% compared to 2017, returned to their home village during *Lebaran* (Haryanti, 2018). Many Indonesian people strive to return to their hometown or village even though they find obstacles, particularly with regard to transportation (see Figure 45).



Figure 45. Passengers scramble entering the train during *mudik Lebaran*

(Kompas/Priyombodo). Reprinted from “Melihat Catatan Mudik dari Tahun ke Tahun...”

by R. Haryanti, 2018. Retrieved from

[https://nasional.kompas.com/read/2018/06/06/16324121/melihat-catatan-mudik-dari-](https://nasional.kompas.com/read/2018/06/06/16324121/melihat-catatan-mudik-dari-tahun-ke-tahun?page=all)

[tahun-ke-tahun?page=all](https://nasional.kompas.com/read/2018/06/06/16324121/melihat-catatan-mudik-dari-tahun-ke-tahun?page=all) Copyright 2018 by PT. Kompas Cyber Media (Kompas

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Appendix B – Javanese Traditional Ceremonies Before and After Birth

B1 – Javanese traditional ceremonies before birth – *Tingkeban*

The usual ceremonies for pregnant women are observed during the second, fourth (“*Ngupati*”), seventh (“*Tingkeban*”), and ninth months of pregnancy (Bratawidjaja, 2000). According to Javanese tradition, a woman who is pregnant needs to be prayed for in ceremonies so the baby will have happiness in the future (Bratawidjaja, 2000; Negoro, 1998a). The ceremony during the 7th month is particularly significant because of the symbolism of the acts undertaken by the family and husband.

The meaning of *Tingkeban* is that learning begins at conception and, therefore, during pregnancy the pregnant woman should only do ‘good things’ and avoid ‘bad things’ so that the baby will become a ‘good’ child (Bratawidjaja, 2000). In the *Tingkeban* ceremony, the pregnant woman is bathed with *kembang setaman* (which consists of rose, yasmin, magnolia, and cananga) and holy water that comes from seven springs. There are special prayers that ask for the blessing of God so that the baby will be born safely (Negoro, 1998a).

According to Negoro (1998a) the *Tingkeban* ceremony consists of:

- *Sraman* (holy bathing) that is done by seven *sesepuh* (older people including the pregnant woman’s parents). The purpose is to purify the pregnant woman and the baby. In addition, seven in Javanese language is *pitu*. It means that the seven *sesepuh* can give *pitulungan* (help).

- The mother-in-law passes an egg inside the *kain* (clothes) that are worn by the pregnant woman hoping the egg will break. This symbolises the hope that the process of delivery will be smooth as the broken egg.
- Changing of the clothes seven times. This consists of placing different clothes on the pregnant woman. The motifs/designs of these clothes are:
 1. *Wahyutumurun* cloth, which denotes that the baby will receive inspiration from God.
 2. *Sidomulyo* cloth, which denotes that the baby will have glory in future life.
 3. *Sidoasih* cloth, which denotes that the baby will receive love from the parents and relatives.
 4. *Sidoluhur* cloth, which denotes that the baby will have divine insight.
 5. *Satriowibowo* cloth, which denotes that the baby will be brave.
 6. *Sidodrajat* cloth, which denotes that the baby will have a good social status.
 7. *Tumbarpecah* cloth, which hopes that the baby will be born smoothly as the broken *tumbar* (coriander).
- Cutting the cord from coconut leaves wound around the pregnant woman's waist. The husband uses *keris* (a wavy double-bladed dagger), the tip of which is covered by turmeric. The significance of him cutting the cord is to simulate an easy birth.
- *Brojolan* (Figure 46): The pregnant woman's mother passes two young yellow *Gading* coconuts inside the *kain* that are worn by the pregnant woman and the mother-in-law receives them at the bottom. The two coconuts are carved with images

of the *God Kamajaya* and *Goddess Kamaratih*. It is hoped the baby will be handsome as *Kamajaya* or will be beautiful as *Kamaratih*.

- The husband cuts the coconuts. The meaning of this is the hope that the baby will be born easily.
- *Dodol dawet* (a kind of dessert). *Dawet* is distributed by the husband and his pregnant wife. The pregnant woman serves the dessert to everybody while the husband receives *kreweng* (ceramic coins) from them.



Figure 46. One part of *Tingkeban* ceremony named *Brojolan* (private photograph was supplied to the researcher).

B2 – Javanese traditional ceremonies after birth – *Mendhem Ari-ari*

After the baby is born, Javanese people also treat the placenta respectfully. They perform a traditional ceremony called *Mendhem Ari-ari* to bury the placenta (*ari-ari* or *aruman*) with respect (Surono, 2011). *Mendhem ari-ari* for Javanese people is a serious matter because *ari-ari* is a spiritual younger brother of the baby that will always follow the baby after s/he is born, and protect the baby from any diseases from the earth and above during the first 35 days and protect the baby's soul (Surono, 2011). In addition, the baby also has a spiritual older brother, *kawah* (amniotic fluid). In this context, Javanese people usually call it *kakang kawah adi ari-ari* (spiritual older brother: amniotic fluid; spiritual younger brother: placenta). Because of this, it is advised that the placenta should be treated respectfully. One such respectful treatment is to bury it in a worthy place with respect (Surono, 2011) in the *Mendhem Ari-ari* ceremony described below.

Firstly, the health care staff, midwife or *dukun bayi* washes the placenta. Then, it is handed to the baby's family in the *kendhil* (clay bowl) that has been provided to the health care staff, or midwives or *dukun bayi* by the baby's family before the birth. The placenta is put on the *senthe* leaves that are placed on the bottom of the *kendhil*. Before it is buried, people usually put some things inside the *kendhil*, such as a flower, fragrant oil, salt, a needle, yarn, a paper with Javanese writings, a paper with Arabic writings, a paper with Latin writings, money, a pencil, and a book. For female babies, people usually also put *empon-empon* into the *kendhil*, such as garlic and a shallot, or yarn and a needle. For

male babies, people usually put in coins of around a hundred rupiahs. The *kendhil* is then closed by the lid and covered by new *mori* clothes (calico) (Surono, 2011).

Before burying the placenta, the burial pit is prepared well. The depth of the burial pit is usually as long as the arm of the digger who is typically the biological father of the baby. There is a tradition regarding the location of the burial pit. For female babies, it is placed on the left side of the main door of the family's house while, for male babies, it is placed on the right side of the main door. It means that a man's position in the family is on the right as the head of the family who works and is responsible for the family while a woman's position in the family is on the left to accompany the husband (Surono, 2011).

The person who has the right to bury the placenta is the biological father of the baby. He has to wear complete Javanese traditional clothing that consists of *bebedan* (wearing cloth or *sarung*) and *blangkon* (a Javanese traditional headgear). If the baby has no father, the grandfather of the baby substitutes in his place. It should be noted that the person who buries the placenta should be male and has the closest biological relationship to the baby (Surono, 2011).

The placenta burial method starts by holding the *kendhil* to the burial pit carefully. Some people use an umbrella to cover the *kendhil*. After that, the *kendhil* is buried with respect. Then, a bamboo fence is built above the burial ground. The burial ground is sprinkled with flowers. There is a light above the burial ground that turns on each night during *selapan* or for 35 days. The aim of providing the light is that the baby will always

receive *pepadhang* (a light in the dark) in order to have a clean or light heart and soul (Surono, 2011).

Appendix C – Ethics Approval from St. Vincentius a Paulo Catholic Hospital



RKZ SURABAYA

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Surabaya, 9 November 2015

No. : 306/SDM/XI/2015

Re : Approval to conduct research

Johanna Natalia, S. Psi., M. Mus.
Ph.D student
School of Psychology and Social Science
Faculty of Health, Engineering and Science
Edith Cowan University
Australia

Dear Johanna Natalia,

HREC Ref. Number: 02/Kom. Etik/X/2015

Project Title:

Having a Known, Trusted Support Person during Labour and Birth: Perceptions of Indonesian Women, Their Support Person and Midwives.

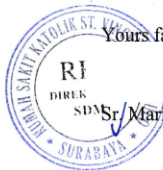
This project submitted on 25 September 2015 was approved by the HREC of St. Vincentius a Paulo Catholic Hospital, Surabaya, Indonesia on 8 October 2015.

Should you wish to discuss this matter, please contact either :

- Prof. dr. Erwin Sarwono, Sp. A (K) (Supervisor)
- DR. B. Triagung Ruddy Prabantoro, dr., Sp. OG (Supervisor)

The HREC of St. Vincentius a Paulo Catholic Hospital Surabaya, Indonesia wishes you every continued success in your research.

Yours faithfully..



Sr/Maria Widjaja, SSps

---- Diselenggarakan oleh Yayasan Arnoldus ----

Appendix D – Ethics Approval from ECU Human Research Ethics Committee (HREC)

Confirmation of Candidature for Natalia PhD (SAH) [Incident: 160211-001580] <https://img.mail.yahoo.com/oev/message?search=1&s=u111dZik...>

Confirmation of Candidature for Natalia PhD (SAH) [Incident: 160211-001580]


Thursday, February 11, 2016 3:54 PM

From: "ECU Student Records" <studentrecords@ecu.edu.au>

To: natef@ecu.edu.au; n_nad@yahoo.com

Cc: c.speelman@ecu.edu.au; s.bayes@ecu.edu.au

Edith Cowan University



Confirmation of Candidature for Natalia PhD (SAH)
 Message By Email (Shelley Hutz) (11/02/2016 03:54 PM)
 11 February 2016

Re: 160211-001580

Dear Ms Natalia,

I am pleased to write on behalf of the Research Students and Scholarships Committee who have approved your PhD research proposal: **Having a known, trusted support person during labour and birth: Perceptions of Indonesian women, their support person and midwives.**

I also wish to confirm that your proposal complies with the provisions contained in the University's policy for the conduct of ethical research, and your application for ethics has been approved. Your ethics approval number is 12779 and the period of approval is 11 February 2016 to 31 August 2017.

Approval is given for your **supervisory team** to consist of:

Principal Supervisor: Professor Craig Speelman – ECU
 Co-Principal Supervisor: Associate Professor Sara Bayes – ECU

The examination requirements on completion are laid down in Part 3A of The University Admissions, Enrolment and Academic Progress Rules for Courses Requiring the Submission of Theses available at: http://www.ecu.edu.au/_data/assets/pdf_file/00005/378820/Admission-Enrolment-and-Academic-Progress-Rules.pdf

Additional information and documentation relating to the examination process can be found at the Graduate Research School website: <http://research.ecu.edu.au/gsr/>

Please note: the Research Students and Scholarships Committee has resolved to restrict doctoral theses to a maximum of 100,000 words with a provision that under special circumstances a candidate may seek approval from the Faculty Research and Higher Degrees Committee for an extension to the word length. (RSSC 96/24).

I would like to take this opportunity to offer you our best wishes for your research and the development of your thesis.

Yours sincerely




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 Date Last Updated: 11/02/2016 03:54 PM
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Appendix E – Indonesian Customs

Flexibility is common in Indonesia. This term has a broad meaning, and can be applied to the observance of time. A very well-known term in Indonesian is “jam karet” (rubber time). It means that the time to start or stop an event can be stretched like rubber which, in effect, means late. It is common that a meeting or an event starts an hour after the time scheduled. Because this is the custom, people usually do not complain about it. They just wait and accept this common custom. A similar thing occurs when people have appointments with others. Researchers have identified that it is common for appointments to be delayed or even cancelled (Business View, 2015; Kwantessential, 2017; Service, 2016; Sivers, 2014; Underhill, 1997). As Underhill (1997) has said, “wasting time” for the Indonesian is a meaningless concept. Indonesians prefer to develop flexible interpersonal skills rather than rigid to the time or rules.

People tend to place more value on harmonious relationship in a flexible, spontaneous, and unstructured way (Underhill, 1997). Making an appointment before visiting a friend is too formal and rigid for human relationships in Indonesia. For example, it is common for people visit other peoples’ houses without an appointment. This may be because they are sure that the house owner would be happy to accept them. It is almost always true that most house owners are very pleased to have a surprise visit from their relatives or friends.

Flexibility can also be observed in using public transport or on the street. For example, the public transport in Indonesia which is named *angkot* (and stand for

angkutan kota, translated as city transport) can stop at any point along the route. It is common that people ask the driver to stop suddenly to leave or ride the vehicle. It means that drivers of other vehicles need to be aware that, if they drive close to public transport, they must be ready to brake if the vehicle suddenly stops or cuts in their way. In addition, many motorcycles also overtake and block the vehicles' way at high speed. This means people should be fully aware on the street. Drivers should always be fully aware and anticipate braking suddenly because of the type of behaviour exhibited by public transport and motorcycle drivers (see Figure 47).



Figure 47. An illustration of traffic in Jakarta. Reprinted from “Lalu Lintas Jakarta, Jalan Jenderal Sudirman dan Cilincing Padat” by R. Fahzry, 2017. Retrieved from <https://news.okezone.com/read/2017/03/27/338/1651821/lalu-lintas-jakarta-jalan-jenderal-sudirman-dan-cilincing-padat> Copyright 2017 by Okezone.com

Appendix F – Recruitment Flyer



Pregnant Women Needed for a Study.



Would you like to share your experience regarding childbirth?

Participants are needed for a study about women's experience during pregnancy and childbirth.

If you think you would be interested in volunteering for this study, or if you require further information, then please contact: Johanna Natalia on +62 31 298 1142.

I am a lecturer at the Faculty of Psychology, University of Surabaya, Indonesia. I am studying for a PhD at the School of Arts and Humanities, Edith Cowan University, Australia.

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by The Human Research Ethics Committee (HREC) at Edith Cowan University, Australia, and St. Vincentius a Paulo Catholic Hospital, Surabaya. For questions regarding participant rights and ethical conduct of research, contact the chair of The Human Research Ethics Committee (HREC) at +61 8 6304 2170 (Edith Cowan University) or +62 31 5677562 (St. Vincentius a Paulo Catholic Hospital).

Supervisor: Professor Craig Speelman

Chief investigator: Johanna Natalia

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E-mail: johanna_natalia@staff.ubaya.ac.id

Appendix G – Participant Information Letter – The Woman



The pregnant woman's experience during childbirth

Introduction

My name is Johanna Natalia, and I am a lecturer at the Faculty of Psychology, University of Surabaya, Indonesia. I am studying for a Doctor of Philosophy degree (PhD) under the supervision of Professor Craig Speelman and Associate Professor Dr Sara Bayes at Edith Cowan University, Australia. My supervisors in Indonesia are Professor Erwin Sarwono, M.D. and B. Triagung Ruddy Prabantoro, M.D from St. Vincentius a Paulo Catholic Hospital, Surabaya.

What is this study about?

Research has shown that support from a trusted companion during childbirth can make a difference to a woman's experience of giving birth. Previous research has explored the presence of a support person during labour and birth in Western societies. What is not known, though, is how companionship in labour affects birthing women in the Eastern world. To inform our understanding, this study will investigate the effect of the presence of a support person on women giving birth in Indonesia.

Why have I been selected as a potential participant?

You have been approached to consider participating in this study because you are pregnant and attending the St Vincentius a Paulo Catholic Maternity Centre for your maternity care, you are planning to have a known and trusted support person with you during labour and while you give birth, and I have been advised by the attending physician, Dr B. Triagung Ruddy Prabantoro M.D., that you are eligible to take part in this research. Please be advised that I have not seen and nor will I ever see your medical records.

What will the study involve for me if I decide to take part?

If, after you have received all the information you require, you decide to participate in this study, you will be asked to complete a consent form. Your support person will accompany you during childbirth to support your labour by saying encouraging words, touching your hands, sitting beside you, etc. I will then meet with you three times to hear about your expectations and experience of giving birth. Firstly, I will meet with you one more time before you have your baby (at one of your antenatal appointments at the Maternity Centre) to talk with you about your expectations for your labour and birth. Secondly, I will visit with you in the early days after your baby's birth to capture your immediate thoughts about your experience of labour and giving birth. Then I will visit with you one last time six weeks after your baby is born to hear again about your experience of labour and birth. In all three interviews I will be particularly interested to

know how you think having a support person will and did make a difference to your birth experience, if at all.

I anticipate the first and third interviews will take between 30-60 minutes depending on how much you have to share with me. Out of respect for the fact that you will have recently given birth and be caring for a new baby, I will make the second interview as brief as possible.

In addition to your participation, we will also invite your labour and birth companion to share their expectations and experience of supporting you during labour and birth. To give us as much information as we can gather about the impact of trusted companionship in labour and birth, the midwife or midwives who care/s for you while you give birth will also be asked about their experience of working with a woman who has a support person with her. In the event that any of these people decide not to take part in the study, we would still want to use the valuable information you provide.

We don't anticipate you will experience any discomfort as a result of participating in this study however if talking about this subject causes you to feel upset or distressed, the interview will be stopped and you will be provided with the contact details for someone from whom you can receive support from The Centre of Counselling and Psychological Service, Faculty of Psychology, University of Surabaya for free.

In the event that your labour and birth do not proceed normally as anticipated, I would still like you to remain in this study and hear about your experience. Please be aware that in this situation (for example if you require medical assistance or a caesarean section to give birth), your birth support person may be asked to leave the room.

What are the possible benefits of participating in the study?

It is unlikely that you will benefit directly and immediately from taking part in this study, although it is possible that reflecting on your experience could lead you to develop some insights into it that you hadn't previously thought of.

If you do decide to take part, the understanding that I gain from your experience will be used to influence midwifery practice and maternity care policy, thus your participation would have an indirect wider benefit for childbearing women and their newborns.

How will the information I provide be used?

Your contact details and interview data will be kept strictly confidential*: only the investigator and her University supervisors will have access to this information, and they will be stored in an electronic database in a password-protected file on a password protected computer for a minimum period of five years (in accordance with Australian National Health and Medical Research Council requirements). At the end of this period, all data will be destroyed beyond recovery. The data collected from you for this study will only be used for this study.

*Please note: there are limits to confidentiality, and we may be required to make available any information that you disclose to us pertaining to illegal behaviour or behaviour that would cause harm to the public if we are asked to do so by relevant legal and professional bodies.

How will the results of the study be shared?

The results of this study will be included in my PhD thesis, in reports to Human Research Ethics Committees, at conferences and in journal publications. The summary of the results of the study will be provided to the participants on request. You can be assured that reports of the study and its findings will not include any information that identifies you.

What should I do if I would like to participate?

If you are willing to take part in this study, please advise the researcher who will then offer you an opportunity to ask any questions about the study, and give you a consent form with instructions for its completion. If you have any questions or require any further information about the research project before you decide whether to participate, please contact us via one of the phone numbers or email addresses below.

Once you have completed and returned the consent form, the researcher will contact you again to arrange a day and time for your first interview.

Participation in this study is voluntary. No explanation or justification is needed if you choose not to participate, and a decision not to participate will not disadvantage you in any way or involve any sort of penalty. Further, if you do decide to take part, you are free to withdraw your consent to continue as a participant up until the point that we have analysed your interview data.

Who should I contact for more information or if I have any concerns

Johanna Natalia is the lead investigator for this study, and her supervisors are Professor Craig Speelman and Associate Professor Sara Bayes; she is also working with Professor Erwin Sarwono, M.D. and B. Triagung Ruddy Prabantoro, M.D.

If you have any questions or concerns about this study you can contact them via one of the phone numbers or email addresses below.

Johanna Natalia

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| <p>Associate Professor Dr Sara Bayes</p> <p>School of Nursing and Midwifery, Edith Cowan University – Australia</p> <p>Phone: +61 8 63043508</p> <p>e-mail: s.bayes@ecu.edu.au</p> |
| <p>Prof. dr. Erwin Sarwono, Sp.A (K)</p> <p>RSK St. Vincentius a Paulo, Surabaya – Indonesia</p> <p>Phone:</p> <p>e-mail:</p> |
| <p>DR. B. Triagung Ruddy Prabantoro, dr., Sp. OG</p> <p>RSK St. Vincentius a Paulo, Surabaya – Indonesia</p> <p>Phone:</p> <p>e-mail:</p> |

If you have any concerns or complaints about the ethical aspects of this research and wish to talk to an independent person, you may contact:

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Email: research.ethics@ecu.edu.au

Ethics Committee

St. Vincentius a Paulo Catholic Hospital

Surabaya

Indonesia

Phone: +62 31 56 77 562

E-mail: diklat@rkzsby.com



Frequently Asked Questions



Why have I been invited?

You are invited to this study because you are pregnant and booked to have a baby during April – December 2016.

What will I need to do?

You will choose a support person who will accompany you when you are giving birth.

You will share your experience regarding your childbirth:

- a. Before childbirth: 2 – 4 weeks before childbirth.
- b. During childbirth: 1 – 2 days after childbirth.
- c. After childbirth: 6 weeks after childbirth.

Do I need to pay?

There is no cost to participate to this study.

What if I do not want to continue to participate to this study?

You are free to participate to this study and may withdraw at any time without penalty

Appendix H – Participant Information Letter – The Support Person



The support person's experience during childbirth

Introduction

My name is Johanna Natalia, and I am a lecturer at the Faculty of Psychology, University of Surabaya, Indonesia. I am studying for a Doctor of Philosophy degree (PhD) under the supervision of Professor Craig Speelman and Associate Professor Dr Sara Bayes at Edith Cowan University, Australia. My supervisors in Indonesia are Professor Erwin Sarwono, M.D. and B. Triagung Ruddy Prabantoro, M.D from St. Vincentius a Paulo Catholic Hospital, Surabaya.

What is this study about?

Research has shown that support from a trusted companion during childbirth can make a difference to a woman's experience of giving birth. Previous research has explored the presence of a support person during labour and birth in Western societies. What is not known, though, is how companionship in labour affects birthing women in the Eastern

world. To inform our understanding, this study will investigate the effect of the presence of a support person on women giving birth in Indonesia.

Why have I been selected as a potential participant?

You have been approached to consider participating in this study because you have been chosen by the pregnant woman who is attending the St Vincentius a Paulo Catholic Maternity Centre for her maternity care, she is planning to have a known and trusted support person with her during labour and while she gives birth, and I have been advised by the attending physician, Dr B. Triagung Ruddy Prabantoro M.D., that she is eligible to take part in this research. Please be advised that I have not seen and nor will I ever see her medical records.

What will the study involve for me if I decide to take part?

If, after you have received all the information you require, you decide to participate in this study, you will be asked to complete a consent form. You will accompany the woman during childbirth to support her labour by saying encouraging words, touching her hands, sitting beside her, etc. I will then meet with you three times to hear about your experience of supporting the woman during her pregnancy and giving birth. Firstly, I will meet with you one more time before she has her baby (at one of her antenatal appointments at the Maternity Centre) to talk with you about your experience supporting the woman during her pregnancy. Secondly, I will visit with you in the early days after

her baby's birth to capture your immediate thoughts about your experience of supporting the woman labour and giving birth. Then I will visit with you one last time six weeks after her baby is born to hear again about your experience of supporting the woman labour and birth. In all three interviews I will be particularly interested to know how you think as a support person and did make a difference to her birth experience, if at all. I anticipate the first and third interviews will take between 30-60 minutes depending on how much you have to share with me. Out of respect for the fact that you will have recently had and be caring for a new baby, I will make the second interview as brief as possible.

In addition to your participation, we will also invite the woman to share their expectations and experience during labour and birth. To give us as much information as we can gather about the impact of trusted companionship in labour and birth, the midwife or midwives who care/s for the woman while she gives birth will also be asked about their experience of working with a woman who has a support person with her. In the event that any of these people decide not to take part in the study, we would still want to use the valuable information you provide.

We don't anticipate you will experience any discomfort as a result of participating in this study however if talking about this subject causes you to feel upset or distressed, the interview will be stopped and you will be provided with the contact details for someone

from whom you can receive support from The Centre of Counselling and Psychological Service, Faculty of Psychology, University of Surabaya for free.

In the event that her labour and birth do not proceed normally as anticipated, I would still like you to remain in this study and hear about your experience. Please be aware that in this situation (for example if she requires medical assistance or a caesarean section to give birth), you may be asked to leave the room.

What are the possible benefits of participating in the study?

It is unlikely that you will benefit directly and immediately from taking part in this study, although it is possible that reflecting on your experience could lead you to develop some insights into it that you hadn't previously thought of.

If you do decide to take part, the understanding that I gain from your experience will be used to influence midwifery practice and maternity care policy, thus your participation would have an indirect wider benefit for childbearing women and their newborns.

How will the information I provide be used?

Your contact details and interview data will be kept strictly confidential*: only the investigator and her University supervisors will have access to this information, and they will be stored in an electronic database in a password-protected file on a password protected computer for a minimum period of five years (in accordance with Australian National Health and Medical Research Council requirements). At the end of this period,

all data will be destroyed beyond recovery. The data collected from you for this study will only be used for this study.

*Please note: there are limits to confidentiality, and we may be required to make available any information that you disclose to us pertaining to illegal behaviour or behaviour that would cause harm to the public if we are asked to do so by relevant legal and professional bodies.

How will the results of the study be shared?

The results of this study will be included in my PhD thesis, in reports to Human Research Ethics Committees, at conferences and in journal publications. The summary of the results of the study will be provided to the participants on request. You can be assured that reports of the study and its findings will not include any information that identifies you.

What should I do if I would like to participate?

If you are willing to take part in this study, please advise the researcher who will then offer you an opportunity to ask any questions about the study, and give you a consent form with instructions for its completion. If you have any questions or require any further information about the research project before you decide whether to participate, please contact us via one of the phone numbers or email addresses below.

Once you have completed and returned the consent form, the researcher will contact the woman or you to arrange a day and time for your first interview.

Participation in this study is voluntary. No explanation or justification is needed if you choose not to participate, and a decision not to participate will not disadvantage you in any way or involve any sort of penalty. Further, if you do decide to take part, you are free to withdraw your consent to continue as a participant up until the point that we have analysed your interview data.

Who should I contact for more information or if I have any concerns?

Johanna Natalia is the lead investigator for this study, and her supervisors are Professor Craig Speelman and Associate Professor Sara Bayes; she is also working with Professor Erwin Sarwono, M.D. and B. Triagung Ruddy Prabantoro, M.D.

If you have any questions or concerns about this study you can contact them via one of the phone numbers or email addresses below.

Johanna Natalia

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| <p>DR. B. Triagung Ruddy Prabantoro, dr., Sp. OG</p> <p>RSK St. Vincentius a Paulo, Surabaya – Indonesia</p> <p>Phone:</p> <p>e-mail:</p> |

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Appendix I – Participant Information Letter – The Midwife



The pregnant woman's experience during childbirth

Introduction

My name is Johanna Natalia, and I am a lecturer at the Faculty of Psychology, University of Surabaya, Indonesia. I am studying for a Doctor of Philosophy degree (PhD) under the supervision of Professor Craig Speelman and Associate Professor Dr Sara Bayes at Edith Cowan University, Australia. My supervisors in Indonesia are Professor Erwin Sarwono, M.D. and B. Triagung Ruddy Prabantoro, M.D from St. Vincentius a Paulo Catholic Hospital, Surabaya.

What is this study about?

Research has shown that support from a trusted companion during childbirth can make a difference to a woman's experience of giving birth. Previous research has explored the presence of a support person during labour and birth in Western societies. What is not known, though, is how companionship in labour affects birthing women in the Eastern world. To inform our understanding, this study will investigate the effect of the presence of a support person on women giving birth in Indonesia.

Why have I been selected as a potential participant?

You have been approached to consider participating in this study because you have helped the pregnant woman who was attending the St Vincentius a Paulo Catholic Maternity Centre for her maternity care, she was planning to have a known and trusted support person with her during labour and while she gives birth, and I have been advised by the attending physician, Dr B. Triagung Ruddy Prabantoro M.D., that she is eligible to take part in this research. Please be advised that I have not seen and nor will I ever see her medical records.

What will the study involve for me if I decide to take part?

If, after you have received all the information you require, you decide to participate in this study, you will be asked to complete a consent form. The woman's support person will accompany her during childbirth to support her labour by saying encouraging words, touching her hands, sitting beside her, etc. I will then meet with you two times to hear about your experience of helping the woman during her giving birth. Firstly, I will visit with you in the early days after her baby's birth to capture your immediate thoughts about your experience of helping the woman labour and giving birth. Then I will visit with you one last time six weeks after her baby is born to hear again about your experience of helping the woman labour and birth. In all two interviews I will be particularly interested to know how you think as a helper and did make a difference to her birth experience, if at all.

I anticipate the first and second interviews will take between 30-60 minutes depending on how much you have to share with me.

In addition to your participation, we will also invite the woman to share their expectations and experience during labour and birth. To give us as much information as we can gather about the impact of trusted companionship in labour and birth, the support person who accompanying the woman while she gives birth will also be asked about his/her experience of supporting the woman who has a support person with her. In the event that any of these people decide not to take part in the study, we would still want to use the valuable information you provide.

We don't anticipate you will experience any discomfort as a result of participating in this study however if talking about this subject causes you to feel upset or distressed, the interview will be stopped and you will be provided with the contact details for someone from whom you can receive support from The Centre of Counselling and Psychological Service, Faculty of Psychology, University of Surabaya for free.

In the event that her labour and birth do not proceed normally as anticipated, I would still like you to remain in this study and hear about your experience. Please be aware that in this situation (for example if she requires medical assistance or a caesarean section to give birth), the support person may be asked to leave the room.

What are the possible benefits of participating in the study?

It is unlikely that you will benefit directly and immediately from taking part in this study, although it is possible that reflecting on your experience could lead you to develop some insights into it that you hadn't previously thought of.

If you do decide to take part, the understanding that I gain from your experience will be used to influence midwifery practice and maternity care policy, thus your participation would have an indirect wider benefit for childbearing women and their newborns.

How will the information I provide be used?

Your contact details and interview data will be kept strictly confidential*: only the investigator and her University supervisors will have access to this information, and they will be stored in an electronic database in a password-protected file on a password protected computer for a minimum period of five years (in accordance with Australian National Health and Medical Research Council requirements). At the end of this period, all data will be destroyed beyond recovery. The data collected from you for this study will only be used for this study.

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How will the results of the study be shared?

The results of this study will be included in my PhD thesis, in reports to Human Research Ethics Committees, at conferences and in journal publications. The summary of the results of the study will be provided to the participants on request. You can be assured that reports of the study and its findings will not include any information that identifies you.

What should I do if I would like to participate?

If you are willing to take part in this study, please advise the researcher who will then offer you an opportunity to ask any questions about the study, and give you a consent form with instructions for its completion. If you have any questions or require any further information about the research project before you decide whether to participate, please contact us via one of the phone numbers or email addresses below.

Once you have completed and returned the consent form, the researcher will contact you to arrange a day and time for your first interview.

Participation in this study is voluntary. No explanation or justification is needed if you choose not to participate, and a decision not to participate will not disadvantage you in any way or involve any sort of penalty. Further, if you do decide to take part, you are free to withdraw your consent to continue as a participant up until the point that we have analysed your interview data.

Who should I contact for more information or if I have any concerns?

Johanna Natalia is the lead investigator for this study, and her supervisors are Professor Craig Speelman and Associate Professor Sara Bayes; she is also working with Professor Erwin Sarwono, M.D. and B. Triagung Ruddy Prabantoro, M.D.

If you have any questions or concerns about this study you can contact them via one of the phone numbers or email addresses below.

Johanna Natalia

ID: 195049

Faculty of Psychology – University of Surabaya

Ph.D. student, Edith Cowan University – Australia

Phone: +62 31 298 1142

e-mail: johanna_natalia@staff.ubaya.ac.id

natalia@our.ecu.edu.au

Professor Craig Speelman

School of Arts and Humanities, Edith Cowan University – Australia

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Associate Professor Dr Sara Bayes

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DR. B. Triagung Ruddy Prabantoro, dr., Sp. OG

RSK St. Vincentius a Paulo, Surabaya – Indonesia

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If you have any concerns or complaints about the ethical aspects of this research and wish to talk to an independent person, you may contact:

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Email: research.ethics@ecu.edu.au

Ethics Committee

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Surabaya

Indonesia

Phone: +62 31 56 77 562

E-mail: diklat@rkzsby.com

Appendix J – Consent Form



Consent Form



I:

Name :

Address :

Phone :

hereby state that I:

- Have been provided with a copy of the Information Letter, explaining the research study.
- Have read and understood the information provided.
- Have been given the opportunity to ask questions and have had any questions answered to my satisfaction.
- Am aware that if I have any additional questions I can contact the research team.
- Understand that my participation in this study will be on the basis that all procedures that participants are requested to participate in will be outlined in the Participant Information Letter.
- Understand that the information provided will be kept confidential, and that the identity of participants will not be disclosed without consent.

- Understand that the information provided will only be used for the purposes of this study, and understand how the information is to be used.
- Understand that I am free to withdraw from further participation at any time, without explanation or penalty.
- Freely agree to participate in this study.

Appendix K– Interview Guidelines

Interview guidelines for the pregnant woman

Before childbirth:

1. How has your pregnancy been?
2. How have you been feeling (about the upcoming birth)?
3. What support have you had from others through your pregnancy (from who, what kind)?
4. How do you feel about the level and type of support you've had?
5. How do you think and feel having/not having a support person in labour will affect you?

During childbirth:

1. Would you please describe the support you received from your support person during childbirth (present enough, too interfering, ... ?) ?
2. How do you feel about the support you received from your support person during childbirth (what difference did it make to your experience (- anxiety, focused?))?
3. How did the midwife deal with you having a support person?
4. How did the support person interact with the midwife?

After childbirth:

1. Would you please describe the support you received from your support person during childbirth (present enough, too interfering, ... ?) ?
2. How do you feel about the support you received from your support person during childbirth (what difference did it make to your experience (- anxiety, focused?))?
3. How did the midwife deal with you having a support person?
4. How did the support person interact with the midwife?
5. Is there anything else you would like to tell me?

Interview Guidelines for The Support Person

Before childbirth:

1. What do you think you'll be doing?
2. How are you feeling about being there?
3. How do you think being there will affect the woman?

During childbirth:

1. Would you please describe your experience related to accompanying the woman during the childbirth?
2. How do you feel about your experience related to accompanying the woman during the childbirth?
3. Would you please describe the support you gave to the woman during the childbirth?
4. How do you feel about the support you gave to the woman during the childbirth?
5. How do you think your presence affected the woman?

After childbirth:

1. Would you please describe your experience related to accompanying the woman during the childbirth?
2. How do you feel about your experience related to accompanying the woman during the childbirth?
3. Would you please describe the support you gave to the woman during the childbirth?
4. How do you feel about the support you gave to the woman during the childbirth?
5. How do you think your presence affected the woman?

Interview guidelines for the midwife/doctor

1. This question will concern how the midwife/doctor felt about, and dealt with, the woman having a birth companion.

(How did you feel about the woman having a birth companion?)

(How did you deal with the woman having a birth companion?)

2. How did you think the support person affected the woman's birth?

Appendix L – Experiences of Interview Schedule Difficulties during Collecting Data

Once I waited almost seven hours at the maternity centre. There was a pregnant woman who needed to undergo urine tests. Because she was a member of the health staff at the hospital, she returned to her department first and promised to see me in an hour when she returned the urinal bottle to the maternity centre. However, she was very busy at her department. I was confused because she cancelled and rescheduled three times. Finally, I interviewed her after she finished working after I had waited almost seven hours since the morning.

Another time, another pregnant woman did not reply to my message until the day of the routine check-up. I assumed that this particular pregnant woman was not interested in my study. However, that morning, I received her message saying that she was at the maternity centre and asked me to come to see her at that time. I needed time to travel there. When I arrived at the maternity centre, the pregnant woman had gone. Fortunately, I then was able to successfully reschedule the interview time.

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